U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Health Resources and Services Administration

HIV/AIDS Bureau
Division of State HIV/AIDS Programs
Ryan White HIV/AIDS Program

HIV Care Grant Program - Part B
States/Territories Formula and AIDS Drug Assistance Program Formula and ADAP Supplemental Awards

Announcement Type: New and Competing Continuation
Announcement Number: HRSA-14-047

Catalog of Federal Domestic Assistance (CFDA) No. 93.917

FUNDING OPPORTUNITY ANNOUNCEMENT

Fiscal Year 2014

Application Due Date: December 9, 2013

Ensure your Grants.gov registration and passwords are current immediately!
Deadline extensions are not granted for lack of registration.
Registration may take up to one month to complete.

10/9/2013 Application Due Date extended till December 9, 2013

9/25/13- Application Due Date extended till November 21, 2013

Release Date: September 20, 2013

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Authority: Sections 2611-23 of title XXVI of the Public Health Service Act, 42 USC 300ff-21-300ff-31a, as amended by the Ryan White HIV/AIDS Treatment Extension Act of 2009 (Public Law 111-87)

EXECUTIVE SUMMARY

The Health Resources and Services Administration (HRSA), HIV/AIDS Bureau (HAB), Division of State HIV/AIDS Programs (DSHAP) is accepting applications for fiscal year (FY) 2014 Ryan White HIV/AIDS Treatment Modernization Act Grant Program - Part B Formula/Base, Minority AIDS Initiative, AIDS Drug Assistance Program Earmark, Pacific Island Jurisdiction, ADAP Supplemental Awards, and Emerging Communities program. The purpose of this grant program is to assist States and Territories in developing and/or enhancing access to a comprehensive continuum of high quality HIV care and treatment for low-income Persons Living with HIV (PLWH). As such, it supports the National HIV/AIDS Strategy (NHAS) goals of: reducing HIV incidence, increasing access to care and optimizing health outcomes, and reducing HIV-related health disparities.

Funding Opportunity Title:	HIV Care Grant Program - Part B
Funding Opportunity Number:	HRSA-14-047
Due Date for Applications:	December 9, 2013
Anticipated Total Annual Available Funding:	$1,300,000,000
Estimated Number and Type of Awards:	59 grants
Estimated Award Amount:	Varies- formula calculation
Cost Sharing/Match Required:	Yes for Part B Formula/Base and ADAP Supplemental when applicable to specific States
Length of Project Period:	1 year
Project Start Date:	April 1, 2014
Eligible Applicants:	All 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the Territories of the Virgin Islands, Guam, American Samoa, the Commonwealth of the Northern Mariana Islands, the Republic of Palau, the Federated States of Micronesia, and the Republic of the Marshall Islands [See Section III-1 of this funding opportunity announcement (FOA) for complete eligibility information.]

All applicants are responsible for reading and complying with the instructions included in HRSA's *SF-424 Application Guide*, available online at *SF-424 Application Guide* except where instructed in this funding opportunity announcement to do otherwise. A short video for applicants explaining the new *Application Guides* is available at http://www.hrsa.gov/grants/apply/applicationguide/.

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I. Funding Opportunity Description

1. Purpose

This announcement solicits applications for fiscal year (FY) 2014 Ryan White HIV/AIDS Program - Part B Formula/Base, Minority AIDS Initiative, AIDS Drug Assistance Program Earmark, Pacific Island Jurisdiction, ADAP Supplemental Awards, and Emerging Communities. The purpose of this grant program is to assist States and Territories in developing and/or enhancing access to a comprehensive continuum of high quality HIV care and treatment for low-income people living with HIV (PLWH). As such, it supports the National HIV/AIDS Strategy (NHAS) goals of: reducing HIV incidence, increasing access to care and optimizing health outcomes, and reducing HIV-related health disparities.

A comprehensive HIV/AIDS continuum of care includes the following core medical services: outpatient and ambulatory health services, AIDS Drug Assistance Program (ADAP) medications, AIDS pharmaceutical assistance (local), oral health care, early intervention services, health insurance premium and cost sharing assistance, home health care, medical nutrition therapy, hospice services, home and community-based health services, mental health services, medical case management, treatment adherence services, and substance abuse outpatient care as well as appropriate supportive services that assist PLWH in accessing treatment of HIV infection that is consistent with HHS Treatment Guidelines. The guidelines provide standards of care recommendations for antiretroviral treatment, including prophylaxis and treatment of opportunistic infections. The current HHS Treatment Guidelines are available at www.aidsinfo.nih.gov.

Comprehensive HIV/AIDS care also includes access to support services: case management (non-medical), child care services, emergency financial assistance, food bank/home delivered meals, health education/risk reduction, housing services, legal services, linguistic services, medical transportation services, outreach services, psychosocial support services, referral for health care/supportive services, rehabilitation services, respite care, residential substance abuse services and treatment adherence counseling.

Important Notes:

- The Ryan White legislation (Section 2618(a)(2)(H)(iii) of the Public Health Service (PHS) Act) includes a hold harmless clause for Part B programs for years 2010 to 2013 only. Therefore, pending any statutory changes, hold harmless will not be a factor in the FY 2014 Ryan White Part B awards.
- Information on Ryan White and the Affordable Care Act along with Policy Clarification Notices can be found at http://hab.hrsa.gov/affordablecareact/.
- The Early Identification of Individuals with HIV/AIDS (EIIHA) requirements in this funding announcement have been updated and streamlined. Please review carefully when preparing this section of the application.
- Information on National HIV/AIDS Strategy (NHAS) is located in the SF-424 Application Guide.

The following information will assist in understanding and completing this year's grant application:

- National Monitoring Standards: Grantees are required to have implemented the Part B National Monitoring Standards at both the grantee and provider/sub-recipient levels.

HRSA has developed and distributed guidelines outlining the responsibilities of HRSA, the grantee, and provider staff. The National Monitoring Standards were updated April 2013 and can be found at: http://hab.hrsa.gov/manageyourgrant/granteebasics.html.

- Part B funds are subject to Section 2612(b)(1) of the PHS Act, which requires that not less than 75 percent of the funds be used to provide core medical services that are needed in the State/Territory for individuals with HIV/AIDS who are identified and eligible under the Ryan White HIV/AIDS Program. Core medical services and support services allowed under Part B are limited to services that are needed for individuals with HIV/AIDS to achieve their medical outcomes as defined by the Ryan White HIV/AIDS Program. The most recent service definitions can be found in the Ryan White Services Report Instructions Manual that is available online at: http://hab.hrsa.gov/manageyourgrant/clientleveldata.html.

2. Background

This program is authorized by the PHS Act, Sections 2611-23 [42 U.S.C. 300ff-21], as amended by the Ryan White HIV/AIDS Treatment Extension Act of 2009 (Public Law 111-87). The U.S. Department of Health and Human Services (DHHS) administers the Ryan White Part B program through the Health Resources and Services Administration (HRSA), the HIV/ AIDS Bureau (HAB), Division of State HIV/AIDS Programs (DSHAP). All 59 States and Territories receive Ryan White Part B Formula/Base and ADAP funding through this program. For more information regarding the Ryan White HIV/AIDS Program, please visit the website: http://hab.hrsa.gov/

II. Award Information

1. Type of Award

Funding will be provided in the form of a formula grant to States/Territories as defined by Title XXVI of the PHS Act as amended by the Ryan White HIV/AIDS Treatment Extension Act of 2009 (Public Law 111-87).

2. Summary of Funding

This program will provide funding during Federal Fiscal Year 2014. Approximately $1,300,000,000 is expected to be available annually to fund fifty-nine (59) grantees. The project period is one (1) year.

Notification of awards will be sent to the Chief Elected Official (CEO) or to the delegated administrative agency responsible for dispersing Part B Grant Program funds.

Part B formula/base, ADAP and Emerging Communities awards are based on the number of reported living cases of HIV/AIDS cases in the State or Territory in the most recent calendar year as confirmed by CDC and submitted to HRSA. Similarly, for grantees applying for MAI formula funds, awards are based on the number of reported and confirmed living minority cases of HIV/AIDS for the most recent calendar year as confirmed by CDC and submitted to HRSA. The most recently completed calendar year ended December 31, 2012. Supplemental ADAP

grants are awarded by formula to states which meet any of the criteria listed in that section of the FOA to purchase medications for PLWH.

Please note that the Secretary may reduce the amounts of grants under Part B to a State/Territory or political subdivision of a State/Territory for a fiscal year if, with respect to such grants for the second preceding fiscal year, the State/Territory or subdivision fails to prepare audits in accordance with the procedures of Section 7502 of Title 31, United States Code. See Section 2682(a) of the PHS Act.

To ensure timely notification of the release of the FY 2014 Part B awards and other important documents relating to the Part B grant, States/Territories must forward personnel, address, and e-mail or telephone changes immediately to the appropriate Grants Management Specialist listed on the State's or Territory's most recent Notice of Award.

III. Eligibility Information

1. Eligible Applicants

The following States and Territories are eligible to apply for program funding: all 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the Territories of the Virgin Islands, Guam, American Samoa, the Commonwealth of the Northern Mariana Islands, the Republic of Palau, the Federated States of Micronesia, and the Republic of the Marshall Islands.

States must designate a lead State/Territory agency that will be responsible for administering all assistance received; conducting a needs assessment and preparing a State/Territory plan; preparing all applications; receiving notices regarding programs; and collecting and submitting to the Secretary every two years all audits from grantees within the State, including an audit regarding funds expended.

2. Cost Sharing/Matching

States meeting the criteria established in Section 2617(d)(1) of the PHS Act for State Match, are required to Match their total FY 2014 Part B Formula (base) and ADAP earmark award as follows. Matching funds are required from States with more than one percent of the total U.S. AIDS cases reported to the CDC during the previous two Federal fiscal years (i.e., 2011 and 2012). These Matching funds can either be in the form of cash or in-kind resources, and can be provided either directly or through donations to the State from public or private entities, in proportion to their Part B funding. The Match begins at $1 in State funds for every $5 in Federal funds and increases to $1 in State funds for every $2 in Federal funds in later years (Section 2617 of the PHS Act).

State/Territory Matching funds for ADAP supplemental drug treatment grants are required in an amount equal to $1 for each $4 of Federal funds provided in the supplemental grant. [See Section 2618(a)(2)(F)(ii)(III) of the PHS Act.] The law also provides for a waiver of the ADAP supplemental Match pursuant to the language in the statute. **Applicants requesting a waiver must include this request in the narrative related to the ADAP Supplemental.**

Part B MAI and Emerging Community funds are exempt from the Matching requirements.

3. Other

Any application that fails to satisfy the deadline requirements referenced in *Section IV.3* will be considered non-responsive and will not be considered for funding under this announcement.

NOTE: Multiple applications from a State or Territory are not allowable.

Maintenance of Effort
Grant funds shall not be used to take the place of current funding for activities described in the application. The grantee must agree to maintain non-Federal funding for HIV-related activities at a level which is not less than the expenditures for such activities during the fiscal year prior to receiving the grant [(see Section 2617(b)(7)(E) of the PHS Act] (i.e., for the FY 2014 application, not less than the level of expenditures during FY 2013)].

Applicants must submit a report with their FY 2014 Part B application that details the year-to-year HIV-related expenditures by the State/Territory for the previous two complete fiscal years in **Attachment 7 Maintenance of Effort (MOE).** The report must include:

- Documentation (or worksheet) indicating that the overall level of HIV-related expenditures has been maintained year-to-year for the previous two complete fiscal years (i.e., 2011, and 2012), and
- A brief narrative explaining any changes in the data set where HIV-related expenditures have been reduced or where the purpose of an HIV-related expenditure has changed.

IV. Application and Submission Information

1. Address to Request Application Package

HRSA ***requires*** applicants for this funding opportunity announcement to apply electronically through Grants.gov. Applicants must download the SF424 application package associated with this funding opportunity following the directions provided at Grants.gov.

2. Content and Form of Application Submission

Section 4 of HRSA's *SF-424 Application Guide* provides instructions for the budget, budget justification, staffing plan and personnel requirements, assurances, certifications, and abstract. You must submit the information outlined in the Application Guide in addition to the program specific information below. All applicants are responsible for reading and complying with the instructions included in HRSA's *SF-424 Application Guide* except where instructed in the funding opportunity announcement to do otherwise.

Application Page Limit
The total size of all uploaded files may not exceed the equivalent of 90 pages when printed by HRSA. The page limit includes the abstract, project and budget narratives, attachments, and letters of commitment and support required in the *Application Guide* and this FOA. Standard OMB-approved forms are NOT included in the page limit. **We strongly urge you to print your application to ensure it does not exceed the specified page limit. .**

Applications must be complete, within the specified page limit, and submitted prior to the deadline to be considered under this announcement.

Program-specific Instructions
In addition to application requirements and instructions in Section 4 of HRSA's *SF-424 Application Guide* (including the budget, budget justification, staffing plan and personnel requirements, assurances, certifications, and abstract), please include the following:

Waivers and Assurances

- Applicants seeking a waiver to the core medical services requirement (Section 2612(b)(2) of the PHS Act) must submit a waiver request either with this grant application, anytime up to the application submission deadline, or up to four months after the grant award for FY 2014. Submission should be in accordance with the information and criteria published by HRSA in the Federal Register Notice, Vol. 78, Number 101, dated Friday, May 24, 2013, and may be found at http://www.gpo.gov/fdsys/pkg/FR-2013-05-24/pdf/2013-12354.pdf . An FY 2014 Part B waiver request must include funds awarded under the MAI. A waiver request that does not include MAI will not be considered. A core medical services waiver request should be included as Attachment 8.

- Ryan White Part B Agreements and Compliance Assurances are included (Appendix A) with this FOA and require the signature of the CEO, or of the CEO's designee. This document should be included as Attachment 12.

Affordable Care Act (ACA)

As part of the Affordable Care Act (ACA), the health care law enacted in 2010, several significant changes have been made in the health insurance market that expand options for health care coverage, including those options for people living with HIV/AIDS. The ACA creates new state-based marketplaces, also known as exchanges, to offer millions of Americans access to affordable health insurance coverage. Under the ACA individuals with incomes between 100 to 400 percent Federal Poverty Level (FPL) may be eligible to receive advance payments of premium tax credits and/or cost-sharing reductions to help pay for the cost of enrolling in qualified health insurance plans and for coverage of essential health benefits. In states that choose to participate in the ACA Medicaid eligibility expands to non-disabled adults with incomes of up to 133 percent of FPL providing new coverage options for many individuals who were previously ineligible for Medicaid. In addition, the law requires health plans to cover certain recommended preventative services without cost sharing making health care affordable and accessible for Americans. These health care coverage options may be reviewed at http://hab.hrsa.gov/affordablecareact/keyprovisions.pdf.

Outreach efforts are needed to ensure that families and communities understand these new health care coverage options and to provide eligible individuals assistance to secure and retain coverage during the transition and beyond. The HIV/AIDS Bureau recognizes that outreach to and enrollment of Ryan White HIV/AIDS Program (RWHAP) clients into the expanded health insurance coverage is critical. As appropriate and allowable by statute, RWHAP grantees are strongly encouraged to support ACA-related outreach and enrollment activities to ensure that clients fully benefit from the new health care coverage opportunities. For more information on allowable outreach and enrollment activities, please see http://www.hab.hrsa.gov/affordablecareact/outreachenrollment.html.

Applicants should provide a brief description of outreach and enrollment activities for RWHAP clients into new health coverage options. Given that the period of performance leads up to and surpasses the first open enrollment period for individuals and families seeking to obtain coverage through state-based marketplaces, grantees should describe how they will help their clients enroll in new health coverage opportunities. Grantees and subgrantees should also assure that individual clients are enrolled in any appropriate health care coverage whenever possible or applicable, and informed about the financial or coverage consequences if they choose not to enroll. For more information on the RWHAP and ACA, visit http://hab.hrsa.gov/affordablecareact/.

For more information on the marketplaces and the health care law, visit http://www.healthcare.gov

Continuum of HIV Care

Identifying people infected with HIV and linking them to HIV primary care with initiation and long-term maintenance of life-saving antiretroviral treatment (ART) are important public health steps toward the elimination of HIV in the United States. The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. The Continuum of HIV Care includes the diagnosis of HIV, linkage to HIV medical care, lifelong retention in HIV medical care, appropriate prescription of ART, and ultimately HIV viral load suppression.

The challenge of executing these lifesaving steps is difficult as demonstrated by the data from the Centers for Disease Control and Prevention (CDC), which estimate that only 25 percent of individuals living with HIV in the United States have complete HIV viral suppression. Data from the Ryan White Service Report (RSR) indicates that there are better outcomes in Ryan White funded agencies with approximately 70% of individuals who received Ryan White funded medical care are virally suppressed. Such findings underscore the importance of supporting effective interventions for linking HIV-positive individuals into care, retaining them in care, and helping them adhere to their combination ART regimens.

Ryan White Part B grantees are encouraged, where possible, to assess the outcomes of their programs along this continuum of care through proactive linkage of surveillance and clinical data. Grantees should work with community partners to improve outcomes across the Continuum of HIV Care, so that individuals diagnosed with HIV are linked and engaged in care and started on ART as early as possible. HAB has worked with other agencies within the Department of Health and Human Services to develop HIV core measures to assist in assessing outcomes along the continuum. HAB encourages grantees to use these performance measures to assess the efficacy of their programs and to analyze and address the gaps along the Continuum of

HIV Care to improve the outcomes of care provided. These efforts are in alignment with and support the goals and objectives of the National HIV/AIDS Strategy.

i. Project Abstract

See Section 4.1.ix of HRSA's *SF-424 Application Guide*.

In addition, the information below should be provided in brief paragraphs:

- General demographics of the State/Territory;
- Demographics of HIV/AIDS populations in the State/Territory;
- Geography of the State/Territory with regard to communities affected by HIV/AIDS and the location of HIV/AIDS services in relation to those communities;
- Description of the continuum of care and treatment offered in the State/Territory, including relevant information about ADAP, primary medical care services, how HIV core services are delivered, and how clients are supported in accessing and remaining in care and treatment; and
- Description of any ADAP restrictions (such as waiting lists, capitations on medications or expenditures, cost shares, or co-pays, etc.).

ii. Project Narrative

This section provides a comprehensive framework and description of all aspects of the proposed project. It should be succinct, self-explanatory and well organized so that reviewers can understand the proposed project.

Use the following section headers for the Narrative.
(A) FY 2014 Part B Formula (Base) Grant Application,
(B) FY 2014 AIDS Drug Assistance Program (ADAP) Grant Application,
(C) Pacific Island Jurisdictions' FY 2014 Part B Grant Application,
(D) ADAP Supplemental Grant Application, and
(E) Emerging Communities FY 2014 Grant Application.

For each header section listed above, use the following subheadings:
Introduction
Needs Assessment
Methodology
Work Plan
Resolution of Challenges
Evaluation
Organization Information

(A) FY 2014 Part B Formula (Base) Grant Application

This Section is to be completed by the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the U.S. Virgin Islands and Guam.

- *INTRODUCTION*

  This section should briefly describe how the State/Territory will utilize Ryan White Part B grant funds in support of a comprehensive continuum of high-quality care and treatment for people living with HIV.

- *NEEDS ASSESSMENT*

1) HIV/AIDS Epidemiology: The purpose of this section is to describe the HIV/AIDS epidemic in the State/Territory. Section 2617 (b) (2) of the PHS Act states that the application for Part B funds shall contain a determination of the size and demographics of the population of people with HIV/AIDS in the State.

Please note that both the Epidemiology table and narrative should be included as **Attachment 5**.

Important Note: *For programs applying for 2014 Part B Supplemental (X08) funds, the Epidemiology table and narrative provided in* ***Attachment 5*** *of this application will be provided to the 2014 Part B Supplemental Objective Review Committee (ORC) reviewers for the purpose of scoring the Epidemiology Data section (Criterion 1) of the Part B Supplemental application. The 2014 Part B Supplemental Funding Opportunity Announcement will* ***not*** *request Epidemiology data.*

a. Table

Summarize in a table format the HIV (non-AIDS) and AIDS Sero-prevalence by age, race/ethnicity, and exposure category through December 31, 2012. Place the table in **Attachment 5** of the application and clearly label the data sources.

b. Narrative

Based on the most recent State HIV/AIDS Epidemiologic Profile, provide a brief narrative description of any trends or changes in the age, race/ethnicity, and exposure categories for prevalent cases and for cases newly diagnosed and reported in the previous two years for which data is available. Place the narrative in **Attachment 5** of the application.

2) Needs Assessment and Public Advisory Planning Process: The purpose of this section is to describe the Needs Assessment process and ensure that public health agencies receiving Part B grants have established a public advisory planning process that includes public hearings, as required by Section 2617(b)(7)(A) of the PHS Act. The public advisory planning process should help the grantee in developing and implementing the Comprehensive Plan and should include individuals living with HIV/AIDS, other Ryan White HIV/AIDS Program grantees, other Federal and local stakeholders, and community leaders. Federally recognized Indian tribes, as represented in the state, must also be represented in the planning process.

a. Needs Assessment

(1) Describe any current or planned needs assessment, including the scope of the needs assessment, who participates in the process, and how participation from PLWH was obtained.

(2) Describe how both the comprehensive plan and the Statewide Coordinated Statement of Need (SCSN) submitted to HRSA during FY 2012 were used as part of this year's needs assessment process.

b. Public Advisory Planning Process

(1) Describe the Public Advisory Planning process model (e.g. integrated care and prevention, statewide or regional) and indicate the number and affiliations of the participating parties, including persons living with HIV/AIDS, other Ryan White HIV/AIDS Program grantees, other HIV related programs, other general and local stakeholder and community leaders.

(2) If the planning entity is not integrated with the CDC HIV Planning Group currently, please indicate if there are plans to integrate and/or what collaborative activities occur currently between the groups.

3) Unmet Need: Unmet Need is defined as the number of individuals for which there is no evidence of any of the following three components of HIV primary medical care during a specified 12 month time frame: viral load (VL) testing, CD4 count, or provision of anti-retroviral therapy (ART). Unmet Need is further defined as the need for HIV-related health services by individuals with HIV who are **aware** of their HIV status, but are not receiving HIV primary health care.

Please note that the Estimated Unmet Need table should be included as **Attachment 8.**

Important Note: *For programs that plan on applying for 2014 Part B Supplemental (X08) funds, the Unmet Need Framework and narrative provided in this application will be provided to the 2014 Part B Supplemental Objective Review Committee (ORC) reviewers for the purpose of scoring the Unmet Need section of the Part B Supplemental application. The 2014 Part B Supplemental Funding Opportunity Announcement will **not** request Unmet Need data. The information provided in **Attachment 8** of this application will be used for scoring purposes.*

a. Provide an updated estimate of unmet need in the jurisdiction using the HRSA/HAB Unmet Need Framework. The framework must include the values, all data sources, and calculations. You may wish to use the automated Excel worksheets of the Framework to help calculate the estimates of unmet need, which you can download from the HAB Web site: ftp://ftp.hrsa.gov/hab/unmetneedpracticalguide.pdf.

b. Provide an Unmet Need Narrative description of the following:

(1) Estimation methods: The methods used to develop the unmet need estimates, reasons for choosing this method, revisions or updates from the FY 2013 estimate, any limitations, and any cross program collaboration that occurred.

(2) Assessment of unmet need: Summarize the findings or results of studies on the demographics of populations and special populations that comprise the unmet need estimate. The Summary should include the following:

a) The demographics and geographic location of people who are aware of their HIV/AIDS status but are not in care;

b) A description of the Unmet Need trends over the past 5 years;

c) An assessment of service needs, gaps, and barriers to care for people not in care.

(3) Addressing unmet need: Describe how the results of the Unmet Need Framework were used in planning and decision making regarding priorities, resource allocations, and

adapting the system of care.

Describe any activities the State/Territory has carried out or is planning to address Unmet Need including the following activities designed to link those aware of their HIV status into core medical services:

a) Outreach activities, Early Intervention Services, Health Education and Risk Reduction;
b) Continuum of Care Activities;
c) Collaboration with Ryan White and non-Ryan White funded entities, including Prevention.

Describe how the program's Unmet Need activities impact service utilization.

Describe the challenges the program has encountered in linking the Unmet Need population to care and how these challenges are being addressed.

(4) Unmet Need Outcomes: Describe the outcomes of the program's FY 2012 Unmet Need activities.

4) Early Identification of Individuals with HIV/AIDS (EIIHA): The purpose of this section is to describe the strategy, plan, and data associated with ensuring that individuals who are unaware of their HIV status are identified, informed of their status, referred to supportive services, and linked to medical care if HIV positive as required in Sec. 2617(b)(8). The goals of this initiative are: 1) increase the number of individuals who are aware of their HIV status, 2) increase the number of HIV positive individuals who are in medical care, and 3) increase the number of HIV negative individuals referred to services that contribute to keeping them HIV negative.

a. EIIHA Plan Background Summary

(1) Please provide the following narrative description of the overall EIIHA Plan since initial implementation:

a) Summary of how the EIIHA Plan was developed and implemented:
   i. What information and/or activities were used to inform the Plan, e.g. unmet need work, outreach activities, epidemiological data?
   ii. What were the main EIIHA Plan objectives?
   iii. What collaborative efforts were required to implement the EIIHA Plan and its objectives? Please specify other programs/agencies participating in the EIIHA Plan development and implementation.
b) Indicate the target groups in the current EIIHA Plan and why each target group was chosen.
c) How has EIIHA related data been collected, analyzed and used to revise implementation activities? Please specifically describe the data sources used in the EIIHA Plan e.g. surveillance, Medicaid, Ryan White program data.
d) Overall, what have been the major successful outcomes of the EIIHA Plan?
e) Overall, what have been the major challenges encountered?
f) How has the EIIHA Plan contributed to achieving the goals of the National HIV/AIDS Strategy?

(2) Select **three** (3) target populations in the current EIIHA Plan. For the selected three

target populations, provide the following data for January 1, 2013 – June 30, 2013:

Newly diagnosed positive HIV test events

a) Number of test events

HIV testing event
An HIV testing event is a sequence of one or more HIV tests conducted with the client to determine his or her HIV status. During a single testing event, a client may be tested once (e.g., one rapid test or one conventional test) or multiple times (e.g., one rapid test followed by one conventional test to confirm a preliminary HIV-positive test result).

b) Number of newly diagnosed positive test events

Newly identified HIV-positive result
An HIV-positive test result associated with a client who does not self-report having previously tested HIV positive and has not been reported to jurisdiction's surveillance department as being HIV positive.

c) Number of newly diagnosed positive test events with client linked to HIV medical care

Linkage to HIV medical care
This calculated indictor determines whether a client with an HIV-positive test result was linked to HIV medical care within 90 days of initial positive test. In order for a client to be linked to care, the client must both be referred to HIV medical care and attend the first medical care appointment.

HIV medical care
HIV medical care includes medical services for HIV infection including evaluation of immune system function and screening, treatment and prevention of opportunistic infections.

d) Number of newly diagnosed confirmed positive test events

Newly identified confirmed HIV-positive result
A confirmed HIV-positive test result associated with a client who does not self-report having previously tested HIV positive and has not been reported to jurisdiction's surveillance department as being HIV positive.

Confirmed HIV-positive result
A testing event with a positive test result for a conventional HIV test (positive EIA test confirmed by supplemental testing, e.g., Western Blot) or a nucleic acid amplification test (NAAT).

e) Number of newly diagnosed confirmed positive test events with client interviewed for Partner Services

Referral to partner services
This calculated indicator determines whether a client with a confirmed HIV-positive test result was given a referral to partner services.

Interviewed for partner services
This calculated indictor determines whether a client with a confirmed HIV-positive test result was interviewed for Partner Services within 30 days of receiving their confirmed positive test result. In order for a client to be counted as interviewed for Partner Services, the client must both be referred to Partner Services and interviewed within 30 days of positive test result.

f) Number of newly diagnosed confirmed positive test events with client referred to prevention services

Referral to prevention services
This indicator determines whether a client with confirmed HIV-positive test results was given a referral to HIV prevention services.

g) Total number of newly diagnosed confirmed positive test events who received CD4 cell count and viral load testing

CD4/VL
This variable indicates whether a client with confirmed HIV-positive test results received CD4 and VL testing.

Previously diagnosed positive HIV test events

a) Number of test events

HIV testing event
An HIV testing event is a sequence of one or more HIV tests conducted with the client to determine his or her HIV status. During a single testing event, a client may be tested once (e.g., one rapid test or one conventional test) or multiple times (e.g., one rapid test followed by one conventional test to confirm a preliminary HIV-positive test result).

b) Number of previously diagnosed positive test events

Previously identified HIV-positive result
HIV-positive test result associated with a client who self-reports having previously tested HIV positive or has been reported to jurisdiction's surveillance department as being HIV positive

c) Number of previously diagnosed positive test events with client re-engaged in HIV medical care

Linkage to HIV medical care
This calculated indictor determines whether a client was linked to HIV medical care within 90 days of the re-diagnosis. In order for a client to be

linked to care, the client must both be referred to HIV medical care and attend the first medical care appointment.

HIV medical care
HIV medical care includes medical services for HIV infection including evaluation of immune system function and screening, treatment and prevention of opportunistic infections.

d) Number of previously diagnosed confirmed positive test events

HIV testing event
An HIV testing event is a sequence of one or more HIV tests conducted with the client to determine his or her HIV status. During a single testing event, a client may be tested once (e.g., one rapid test or one conventional test) or multiple times (e.g., one rapid test followed by one conventional test to confirm a preliminary HIV-positive test result).

Confirmed HIV-positive result
A testing event with a positive test result for a conventional HIV test (positive EIA test confirmed by supplemental testing, e.g., Western Blot) or a nucleic acid amplification test (NAAT).

e) Number of previously diagnosed confirmed positive test events with client interviewed for Partner Services

Referral to partner services
This calculated indicator determines whether a client with a confirmed HIV-positive test result was given a referral to partner services.

Interviewed for partner services
This calculated indictor determines whether a client with a confirmed HIV-positive test result was interviewed for Partner Services within 30 days of receiving their confirmed positive test result. In order for a client to be counted as interviewed for Partner Services, the client must both be referred to Partner Services and interviewed within 30 days of positive test result.

f) Number of previously diagnosed confirmed positive test events with client referred to prevention services

Referral to prevention services
This indicator determines whether a client with confirmed HIV-positive test results was given a referral to HIV prevention services.

g) Number of previously diagnosed confirmed positive test events linked to and accessed CD4 cell count and viral load testing

CD4/VL
This variable indicates whether a client with confirmed HIV-positive test results received CD4 and VL testing.

b. FY14 EIIHA Plan

The overarching goal of the EIIHA Plan is to reduce the number of undiagnosed and late diagnosed HIV positive individuals and to ensure that they are accessing HIV care and treatment.

(1) Describe the planned activities of the State EIIHA Plan for FY14. Include the following information:

a) An updated estimate of individuals who are HIV positive and do not know their status, including the estimate methodology;
b) The target populations for the EIIHA Plan;
c) The primary activities that will be undertaken, including system level interventions e.g. routine testing in clinical settings, expanding partner services;
d) Major collaborations with other programs and agencies, including HIV prevention and surveillance programs; and
e) The planned outcomes of the overall EIIHA strategy.

(2) Describe how the overall FY14 EIIHA Plan contributes to the goals of the National HIV/AIDS Strategy.

(3) Describe how the Unmeet Need estimates and activities inform and relate to the EIIHA planned activities.

(4) Describe any planned efforts to remove legal barriers, including State laws and regulations, to routine HIV testing.

(5) Select three (3) distinct target populations for the FY14 EIIHA Plan. For each selected target population describe:

a) Why the target population was chosen and how the epidemiological data, unmet need estimate data, or other data supports that decision;
b) Specific challenges with or opportunities for working with the targeted population;
c) The specific activities that will be utilized with the target population;
d) Specific objectives for each component of EIIHA (identify, inform, refer, and link to care) for the target population (all objectives should be written as SMART objectives – Specific, Measurable, Achievable, Realistic, and Time Sensitive);
e) The responsible parties, including any coordination with other agencies and/or programs for ensuring each of the activities are implemented, and their respective roles;
f) Planned outcomes that will be achieved for the target population as a result of implementing the EIIHA Plan activities.

(6) Describe plans to present, discuss, and/or disseminate the EIIHA Plan and outcomes e.g. poster presentations, journal articles, presentations to planning bodies.

- *METHODOLOGY*

1) Third Party Reimbursement/Payer of Last Resort: The Ryan White HIV/AIDS Program is the payer of last resort, and grantees must ensure that alternate sources of

payment are pursued. Grantees are expected to coordinate effectively with third party payers to ensure that costs are recovered for services provided to eligible/covered individuals. Third party sources include Medicaid, Children's Health Insurance Programs (CHIP), Medicare (including the Part D prescription benefit) and private insurance, including insurance obtained through the Marketplaces. Subcontractors providing Medicaid eligible services must be Medicaid certified.

Note: *The Indian Health Service is exempt from the payer of last resort provision.*

Provide a narrative that describes the following:

a. The client eligibility criteria for clients who are supported with Ryan White HIV/AIDS Part B Program services. Indicate the client eligibility determination process including how the State/Territory verifies eligibility or conducts certification of clients with other programs including Medicaid, State Pharmacy Assistance Programs (SPAPs), and Children's Health Insurance Programs (CHIP) at least every six months (Please see HAB Policy 13-02). http://hab.hrsa.gov/manageyourgrant/policiesletters.html
b. How contractors/sub-grantees document that clients have been screened for and enrolled in eligible programs such as Medicare, Medicaid, private health insurance or other programs to ensure that Part B funds are the payer of last resort, as well as the frequency of this screening (Please see HAB Policy 13-02). http://hab.hrsa.gov/manageyourgrant/policiesletters.html
c. The process used by the State/Territory to ensure that all contractors/sub-grantees, including consortia contractors/subcontractors, are accessing, receiving, tracking and documenting third party reimbursement. Also describe the contract language or other mechanism to ensure that this takes place.
d. Please describe any recent changes to the State Medicaid program, including a Medicaid expansion, Affordable Care Act marketplace which have impacted, or may impact, the Ryan White Part B program. (i.e. changes in eligibility, charges to clients, etc.). Describe the impact these changes have had, or may have in the future, on the Ryan White Part B program. (i.e. increased enrollment in Ryan White services, increased usage of ADAP, etc.)

2) Women, Infants, Children and Youth Proportionate Spending: Grantees are required to use a proportionate amount of their grant dollars to provide services to women, infants, children and youth (WICY) living with HIV/AIDS, unless a waiver is obtained. Grantees demonstrate compliance with the WICY expenditure requirement in their annual progress report and may request a waiver as part of the annual progress report. Describe the method used by the State/Territory to document that it meets the legislative requirement for proportionate spending on services to women, infants, children and youth. For States/Territories with Consortia, describe how the State ensures compliance with WICY expenditure requirements.

3) Care and Prevention in the United States (CAPUS): As part of the National HIV/AIDS Strategy's (NHAS) goals and to address the social, economic, clinical and cultural barriers that result in disparities in timely HIV diagnosis and access to and retention in HIV care, CDC provided funding to eight (8) states that have a high burden of HIV among African-Americans and Latinos. The grantees are:

Georgia, Illinois, Louisiana, Mississippi, Missouri, North Carolina, Tennessee and Virginia. For more information on CAPUS please refer to the website: at: http://www.cdc.gov/hiv/prevention/demonstration/capus/index.html

Important Note: *Only those eight states listed above (Georgia, Illinois, Louisiana, Mississippi, Missouri, North Carolina, Tennessee, and Virginia) need to respond to the two questions below:*

a. Describe the planned activities of the Ryan White Part B program in collaborating with CAPUS initiative. Please include a timeline for each activity, as well as responsible parties.
b. Describe the plans to sustain the Ryan White Part B CAPUS related activities in future years.

- *WORK PLAN*

Describe the activities or steps that will be used to achieve each of the activities proposed during the entire project period in the Methodology section. This should be presented in the form of a work plan and a narrative.

1) FY 2014 Implementation Plan Table: In a table, list each service category and amounts for all Part B funding sources to include*:* Part B Formula funding, AIDS Drug Assistance Program (ADAP), Minority AIDS Initiative (MAI), ADAP Supplemental (if applicable), and Emerging Communities (if applicable) that will be allocated for each service category in FY 2014. Do not include any administrative processes. The table should be placed in **Attachment 6**.

For each service category listed please provide:

- Objective/s: List objectives for new or continued services. Each objective should describe the specific activities associated with the service being provided.
- Service Unit Definition: Provide the name and definition of the unit of service to be provided (e.g. one round-trip bus ride, one prescription).
- Quantity: Provide the number of people to be served and service units to be provided during the grant year. Section 3a) List the number of people to be served; 3b) List the total number of service units to be provided to that number of individuals.
- Time Frame: Indicate the estimated duration of the activity relating to the objective listed.
- Funds: Provide the approximate amount of Part B funds to be used to provide this service. Where multiple objectives exist beneath one service goal, break out the estimated amount of funding by each individual objective listed.
- Outcome: Select a minimum of two objectives and list planned client level outcomes/indicators to be tracked and include benchmarks for each. HAB developed Standard Outcome Measures for Core Medical Services and Support Service Categories.

2) FY 2014 Implementation Plan Narrative

Provide a narrative that describes the following:

a. How the activities described in the plan will provide increased access to the HIV

continuum of care;

b. How the activities in the plan address unmet need and reduce the number of persons out of care;
c. How the activities in the plan address individuals who are unaware of their HIV status with regard to identifying them, making them aware of their status, referring them to care, and linking them to care;
d. How the activities described in the plan will ensure geographic parity in access to HIV/AIDS services throughout the State or Territory;
e. How the activities described in the plan will address the needs of emerging populations;
f. How the activities described in the plan will ensure that PLWH remain engaged in HIV/AIDS primary medical care and adhere to HIV treatments;
g. How the State/Territory will ensure that resource allocations for services to women, infants, children, and youth (WICY) are in proportion to the percentage of the States/Territories HIV disease cases represented by each population (WICY tables will be provided by HRSA);
h. Briefly describe how proposed FY 2014 allocations address significant issues and core service needs identified in the most recent State-wide Coordinated Statement of Need (SCSN) and Comprehensive Plan; and
i. How the services and their goals and objectives relate to the goals of the Healthy People 2020 initiative, particularly the objectives related to HIV listing under the tab "2020 topics and objectives." See the HRSA SF-424 Application Guide for the link to "Healthy People 2020"

At the end of the Implementation Plan Narrative, provide a brief description of outreach and enrollment activities to enroll Ryan White HIV/AIDS Program clients into the new health coverage options under the Affordable Care Act. Use the Ryan White and the Affordable Care Act: What You Need to Know website to access the "Outreach, Enrollment and Benefits Counseling" guidance (March 12, 2013)" (http://hab.hrsa.gov/affordablecareact/outreachenrollment.html) to develop the activities.

3) FY 2014 MAI Planning and Implementation: The purpose of this section is to provide a narrative description of the implementation plan for the State/Territory to increase racial and ethnic minority populations' participation in the ADAP through MAI-funded education and outreach services. Please indicate in **Attachment 6** whether the program intends to decline MAI funds.

a. **Provide a description of the FY 2014 MAI planning process in terms of:**
   (1) How program results and data generated from previous MAI-funded outreach/education and/or other Part B funded outreach activities are used to increase racial and ethnic minority population participation in the ADAP.
   (2) How persons living with HIV/AIDS, particularly minority individuals, provided input into the MAI planning process.

Coordination of MAI Services and Funding Streams: Ryan White Part B MAI planning efforts should be coordinated with all other local funding streams for HIV/AIDS to:

- *Ensure that Ryan White HIV/AIDS Program funds are the payer of last resort;*
- *Maximize education and outreach efforts to link racial and ethnic minorities to*

the ADAP; and

- *Reduce duplication of services and efforts.*

b. **Describe how the following have been taken into consideration and how they will be coordinated with Part B MAI funds:**

(1) Education and outreach services provided by other Ryan White programs within the State/Territory that are intended to increase access to ADAP.

(2) Education and outreach services funded by other Federal, State, and Local resources, such as CDC HIV Prevention Services, Medicaid, Medicare Part D, and SAMHSA substance abuse and mental health treatment services.

c. **MAI Plan Narrative and ADAP Capacity:** Please describe the FY14 MAI Plan, including:

(1) How education and outreach services will be provided, in terms of:

- Geographic locations;
- Types of agencies and staff to provide services;
- Coordination with existing services and providers;
- Involvement of targeted minority populations in implementation of plan.

d. **Provide an update on the capacity of the ADAP to absorb additional clients (specify the number) reached through MAI-funded services.**

e. **To the extent that ADAP resource constraints may exist, describe the plan to ensure that clients not currently enrolled in ADAP are linked to other medication/treatment resources in a timely manner.**

f. **Describe the plan for assuring the quality of MAI-funded education and/or outreach services in relation to the FY 2014 Part B/ADAP Clinical Quality Management (CQM) plan.**

- *RESOLUTION OF CHALLENGES*

1) **Needs Assessment and Public Advisory Planning Process**: Discuss challenges that are likely to be encountered in implementing the activities in this section and describe approaches that will be used to resolve those challenges.

2) **Unmet Need**: In addition to the responses provided in the Unmet Need section, discuss any other challenges and describe approaches that will be used to resolve those challenges. If there are no additional challenges, please indicate that here.

3) **Early Identification of Individuals with HIV/AIDS**: In addition to the responses provided in the EIIHA section, discuss any other challenges that are likely to be encountered in implementing the activities in this section and describe approaches that will be used to resolve those challenges. If there are no additional challenges, please indicate that here.

4) **Third Party Reimbursement/Payer of Last Resort**: Discuss challenges that are likely to be encountered in implementing the activities in this section and describe approaches that will be used to resolve those challenges. If there are no challenges,

please indicate that here.

5) **WICY Proportionate Spending**: Discuss challenges that are likely to be encountered in implementing the activities in this section and describe approaches that will be used to resolve those challenges. If there are no challenges, please indicate that here.

6) **Clinical Quality Management**: Discuss challenges that are likely to be encountered when designing and implementing clinical quality improvement projects. Describe approaches that will be used to resolve such challenges.

- *EVALUATION AND TECHNICAL SUPPORT CAPACITY*

1) <u>Clinical Quality Management:</u> The purpose of this section is to describe the State's/Territory's overall Clinical Quality Management (CQM) program for Ryan White Part B, including ADAP. This should include a description of how the results of the Ryan White Part B CQM activities are being or have been used to improve service delivery in the State/Territory. Any CQM collaborations with other entities including other Ryan White funded programs, other government entities such as the Centers for Disease Control and Prevention (CDC), National Institutes of Health (NIH), other state and local government programs and non-governmental organizations, including faith-based organizations, should be included.

The Ryan White legislation requires that Ryan White Part B grantees "provide for the establishment of a clinical quality management program to assess the extent to which HIV health services provided to patients under the grant are consistent with the most recent Public Health Service guidelines (also known as the HHS Clinical Guidelines) for the treatment of HIV/AIDS and related opportunistic infection, and as applicable, to develop strategies for ensuring that such services are consistent with the guidelines for improvement in the access to and quality of HIV health services." The legislation allows grantees to use 5% of the grant award or $3,000,000, which ever amount is less, for the activities associated with a clinical quality management program, and states that CQM is not counted towards the administrative expense cap (Section 2618(b)(3)(E) of the PHS Act).

CQM data play a critical role in helping to identify needs and gaps in services as well as in helping to ensure the delivery of quality services to clients. CQM program data and client-level health outcomes data should be used as part of the State/Territory planning process and ongoing assessment of progress toward achieving program goals and objectives. This data should also be used by the grantee to examine and refine processes for administering the grant at the programmatic and fiscal levels.

***<u>Note</u>**: The HAB currently has a portfolio of performance measures that include clinical, systems, medical case management, oral health, and ADAP. Grantees can select appropriate performance measures from the portfolio to compose a "local" portfolio of measures. Grantees are encouraged to pick measures for each funded service category for their portfolio and have a mix of process, outcome and satisfaction measures. Grantees should select performance measures that are most important to their programs and the populations they serve. The HAB performance measures, as well as frequently asked questions, can be found online at:*

http://hab.hrsa.gov/deliverhivaidscare/habperformmeasures.html

Links to the HHS HIV/AIDS guidelines (formerly called the Public Health Service guidelines), the Ryan White legislation, and the resources and technical assistance available to grantees with respect to improving the quality of care and establishing CQM programs may be found online at:
http://hab.hrsa.gov/manageyourgrant/granteebasics.html.

The HAB Part B Program Monitoring Standards (including the standards for Quality Management) can be found online at:
http://hab.hrsa.gov/manageyourgrant/files/programmonitoringpartb.pdf

a. **Description of CQM Program:** Provide a narrative that describes the State/Territory's overall CQM program. Include a detailed description of the CQM plan as outlined below. The description should include specific references to the CQM activities of the ADAP program of the State/Territory. Provide specific references to how the quality CQM program helps to ensure quality care delivery in keeping with the HHS Clinical Guidelines.
(1) Mission statement describing the overall goal of the CQM program including the internal and external expectations.
(2) Description of the infrastructure including the leadership and quality management committee/team members' roles and responsibilities. Include:
    - Number of staff FTE's assigned to CQM
    - Staff members accountable for the CQM program activities
    - Structure of the CQM committee/ team
    - Resources to be used to conduct CQM program activities

(3) Description of selected performance measures and how the measurements will be accomplished. Specify the performance measures that are presently being monitored including service category.
(4) Discussion of the annual quality goals for the upcoming year. Include a description of the process used to determine priorities for the quality improvement projects and the development and monitoring of the quality improvement projects.
(5) Description of the engagement with the internal and external stakeholders including consumers, providers, sub-grantees and other Ryan White HIV/AIDS Programs. List CQM resources and training provided to grantee staff, quality management committee/team, and sub-grantees.
(6) Evaluation of the CQM program including the following:
    - Description of the internal process to assess the CQM program.
    - Description of how the CQM program is implemented, monitored, and evaluated. Included specific activities to assess the quality of services provided by providers/ sub-grantees.
    - Description of the specific quality improvement projects that are currently being implemented within the State/Territory. Discuss how CQM data have been used to improve and/or change service delivery in the State/Territory, including strategic long-range service delivery planning.

b. **Data for Quality and Program Reporting**
(1) Name and describe the Information/Data System(s) within the State/Territory

used for data collection and reporting operations.
(2) Describe what CQM data have been collected to date, and provide a summary of results, including any trending data on outcomes and impact of quality improvement projects.
(3) Describe how the CQM data was reviewed and validated by the grantee, and how the CQM data and analysis was shared with stakeholders; and
(4) Describe the grantee's current client level data collection capabilities included in the Ryan White Service Report (RSR) and the AIDS Drug Assistance Program (ADAP) Data Report (ADR). Include the percentage of providers that are able to report client level data. For calendar years 2011 and 2012, describe the process used to collect and report to HRSA client level data (RSR) from all core medical and support service providers.

c. **Clinical Quality Management: Describe the system and processes that will support** the CQM program's requirements through effective tracking of performance outcomes. Include a description of how data is to be collected and managed that allows for accurate and timely reporting of performance measures. Describe the data collecting strategy to collect, analyze, and track data to measure process and impact outcomes of different cultural groups (e.g. race, ethnicity) and explain how data will be used to inform program development and service delivery.

- *ORGANIZATIONAL INFORMATION*

1) **Grantee Administration and Accountability:** The purpose of this section is to demonstrate the extent to which the Chief Elected Official in the State/Territory has met the legislative requirements to disburse funds quickly, closely monitor their use, and to ensure that the State/Territory has complied with the Ryan White HIV/AIDS Program legislative mandates for payer of last resort, maintenance of effort (MOE), and the minimum expenditure requirement to provide services to Women, Infants, Children and Youth (WICY).

a. **Program Organization**
Provide a description of how Part B funds are administered in the State/Territory with reference to the positions, including fiscal staff that are located outside of the Part B program staff personnel, described in the budget, budget narrative, and the organizational chart included in **Attachment 1**.

b. **Fiscal and Program Monitoring**
HRSA/HAB holds grantees accountable for the expenditure of funds awarded under Part B, and expects grantees to monitor fiscal and programmatic compliance with all contracts and other agreements for HIV/AIDS services in the State/Territory, including contracts with consortia. Grantees are also required to have on file a copy of each contractor's procurement documents (contracts), and fiscal and programmatic site visit reports. The HAB\DSHAP National\Universal monitoring standards and be found at: http://hab.hrsa.gov/manageyourgrant/granteebasics.html

2) Provide a narrative that describes the following:

a. The role and responsibilities of program and fiscal staff in ensuring adequate

reporting, reconciliation, and tracking of program expenditures and program income. Describe the process and coordination methods used by program and fiscal staff to ensure adequate and accurate tracking, reporting, and reconciliation of program expenditures and program income;

Example: The program and fiscal staff's meeting schedule and how fiscal staff share information with program staff regarding contractor expenditures, unobligated balances broken out by grant component (i.e., base, ADAP, ADAP Supplemental, Emerging Communities, MAI, carryover, rebates), and program income.

b. The process used to separately track Ryan White Part B formula/base, ADAP Base, ADAP Supplemental (if applicable), Emerging Communities (if applicable) and MAI (if applicable) grant funds; and the unobligated and carryover funds for each of these grant fund categories as applicable. Include information about the data system(s) utilized to track funds;
c. Description of process and mechanisms used to ensure that providers funded through multiple Ryan White parts (i.e. Parts A, B, C, D, or F) are able to accurately track clients and expenditures and avoid duplication of services;
d. The process used for fiscal and program monitoring, including the type and frequency of required reports;
e. The process and timeline for corrective actions when a fiscal or program–related concern is identified;
f. The process, including a timeline, for receiving vouchers or invoices from providers/subcontractors;
g. The process, including a timeline, for issuing payments to providers/subcontractors, from receipt of voucher/invoice to reimbursement;
h. Describe the ongoing progress by the grantee to implement the National Monitoring Standards;
i. The total number of contractors, including consortia, funded in FY 2013; and
j. The total number of contractors, including consortia, funded in FY 2013, the number and percentage of contractors that received a fiscal and/or programmatic monitoring site visit as of June 2013, as well as the total number expected to be completed by the end of the budget period on March 31, 2014. Also provide answers to the following:
   (1) Were there improper charges by contractors or other findings in FY 2013? If so, please summarize the corrective actions planned or taken to resolve these findings.
   (2) The number of contractors that received technical assistance (TA) during FY 2013 including the types of TA, scope, and timeline.
   (3) The number and percentage of eligible contractors compliant with audit requirements in OMB Circular A-133. Indicate if there were any findings in subcontractors' A-133 audit reports. Describe the measures taken by the grantee to ensure that subcontractors have taken appropriate corrective action.
   (4) For those applicants with consortia, describe the State's monitoring requirements for consortia in relation to their contractors and subcontractors, including how those requirements and processes have been revised to comply with the National Monitoring Standards.

(B) FY 2014 AIDS Drug Assistance Program (ADAP) Grant Application

This Section is to be completed by the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the U.S. Virgin Islands, Guam and eligible Pacific Island Jurisdictions.

The purpose of this section is to describe the State/Territory's AIDS Drug Assistance Program (ADAP). In addition, states and territories that had a waiting list in FY 2013 or anticipate instituting an ADAP waiting list for FY 2014 will be required to respond to the questions listed in sections **(3), (4), and (5)** of this application.

ADAP pays for medications to treat HIV disease, health insurance coverage for eligible clients, and services that enhance access, adherence, and monitoring of medication treatment. Clients must be HIV positive. Financial and residency eligibility criteria are established by the State or Territory. Financial eligibility is usually determined as a percentage of the Federal Poverty Level (FPL). Clients must also provide proof of current state residency. The ADAP must also determine if an individual is uninsured or under- insured. ADAPs are required to recertify client eligibility at least every six months or have systematic processes approved by HRSA that continually screen eligible clients for continued eligibility.

Despite appropriation increases, steady growth in the number of eligible clients combined with rising costs of complex HIV/AIDS treatments sometimes results in states experiencing greater demand for ADAP services than available resources can cover. In these instances, ADAPs have implemented waiting lists or cost containment measures for program services and medications.

An ADAP waiting list is a mechanism used to limit access to the ADAP when funding is not available to provide medications to all eligible persons requesting enrollment in that State. The ADAP verifies overall eligibility for the program and places eligible individuals on a waiting list, as necessary, prioritized by a pre-determined criterion. The ADAP manages the waiting list to bring clients into the program as funding becomes available.

There are two categories of cost-containment measures (CCMs): *cost-cutting* and *cost-saving*

Cost-cutting measures: Any measures taken that restrict/reduce enrollment or that reduce benefits and are instituted out of necessity due to insufficient resources and/or to avoid starting a waiting list. Examples of "cost-cutting" measures**:** reductions in ADAP financial eligibility below 300 percent of the Federal Poverty Level (FPL), capped enrollment, formulary reductions in with respect to antiretroviral medications and/or medications to treat opportunistic infections and complications of HIV disease, or restrictions with respect to ADAP assistance with health insurance coverage eligibility criteria (i.e., below 300% of FPL).

Cost-saving measures: Any measures taken to improve the cost-effectiveness of ADAP operations, which are required to achieve, improve, and/or maximize HRSA recommended cost-saving strategies that all states should be working to achieve and/or maximize regardless of financial status. Examples of "cost-saving" measures: Improved systems and procedures for back billing Medicaid, improved client recertification processes, Part B Program structural or operational changes such as expanding insurance assistance, purchase of insurance, collection of 340B rebates for insurance co-pays, deductibles, co-insurance, and CMS data-sharing agreements related to and Medicare Part D TrOOP expenditures.

HRSA has prioritized the following cost containment strategies through its monitoring and technical assistance efforts**:** purchase of insurance, collection of 340B rebates for insurance co-pays, deductibles, co-insurance, back billing of Medicaid, and CMS data-sharing agreements related to and Medicare Part D TrOOP expenditures, 6-month re-certification, and controlling ADAP administrative costs.

- *INTRODUCTION*

This section should briefly describe how the project will use grant funds to pay for medications to treat HIV disease, health insurance coverage for eligible clients, and services that enhance access, adherence, and monitoring of medication treatment.

- *NEEDS ASSESSMENT*

This section should provide a detailed description of the needs assessment process for ADAP clients and services including client utilization, environmental factors, and implementation of cost-cutting and cost-saving measures.

Client Utilization of ADAP Services

- Provide a narrative describing the demographics of the ADAP population in the State. Discuss any significant difference in the ADAP population and the epidemiological data.
- Discuss the driving factors for any increases in the ADAP enrollment (e.g. MAI Outreach, EIIHA activities, CDC testing initiatives, economic recession, changes in the Medicaid program) and the subsequent impact on utilization of ADAP resulting from these initiatives.
- Provide a narrative that explains how ADAP clients in outlying or rural areas access ADAP services.
- For States and Territories that implemented any "cost-cutting" measures to the ADAP (i.e., waiting lists, enrollment limits, expenditure caps, formulary reductions, etc.) at any point during FY 2013, please describe the rationale for these restrictions and the processes used to both establish and remove them.

- *METHODOLOGY*

This section should describe the methods that will be used by the grantee to address the ADAP needs identified in the Needs Assessment section above. Include any changes that have an impact on ADAP resources, formulary, and cost-saving strategies.

1) ADAP Funding Resources

Provide a table that lists all sources of funds for the ADAP program, including State funds, other Ryan White HIV/AIDS Program funds, and medication rebates, expected for FY 2013. The table should be included as **Attachment 4**. Indicate if there are anticipated funding shortfalls and by what amount.

2) Formulary

The current statute requires that all States/Territories determine the ADAP formularies from the list of core classes of antiretroviral medications established by the Secretary. ADAPs are required to include at least one drug from each FDA-approved antiretroviral drug classes currently available including: Fusion/Entry Inhibitors, Non-nucleoside Reverse Transcriptase Inhibitors, Nucleoside/Nucleotide Reverse Transcriptase Inhibitors,

Protease Inhibitors and Integrase Inhibitors. Please refer to Section 2616(c)(1) of the PHS Act. ***Note:*** *The minimum formulary requirement does not apply to multi-class combination products.*

a. Provide a narrative that discusses any limitations or barriers that affect the inclusion of these drug classes on the State/Territory ADAP formulary.
b. If the ADAP program reduced the number of medications available in the core classes, please describe the process that the ADAP utilized to reduce those medications, and the role of the ADAP Advisory Committee in the reduction process.

3)_ADAP Cost Saving Strategies

ADAP grantees are required to use every means at their disposal to secure the best price available for all products on their ADAP formularies in order to achieve maximum results with these funds. As covered entities, ADAPs are eligible to participate in the 340B Drug Pricing Program under section 340B of the PHS Act. Funds received as a result of participating in the 340B Drug Pricing Program Rebate Option must be returned to the Ryan White Program with priority given to ADAP. Grantees are expected to coordinate effectively with third party payers to ensure that costs are recovered for services provided to eligible/covered individuals. Third party sources include Medicaid, Children's Health Insurance Programs (CHIP), Medicare (including the Part D prescription benefit) and private insurance, including insurance purchased through the Marketplaces. Subcontractors providing Medicaid eligible services must be Medicaid certified. The Ryan White HIV/AIDS Program is the payer of last resort, and grantees must ensure that alternate sources of payment are pursued. Grantees are required to determine client eligibility on an annual/12 month basis and to recertify eligibility every six months. The applicant must ensure that program income is used consistently with ADAP requirements which impact the pharmacy network, the Pharmacy Benefits Management System (PBM), and overall pharmacy costs. Provide the following:

a. A description of the pharmacy network including the number of participating pharmacies.

b. A name of the pharmacy benefits manager (if applicable) and a description of the services provided through the PBM.

c. The amounts expended for dispensing and service delivery.

d. All 340B Participating ADAPs
   For States/Territories that participated in the 340B Drug Pricing Program during FY 2013, respond to the following questions specific to the cost-saving practices used:
   (1) 340B Direct Purchase
      a) Describe the State/Territory's cost-saving practices for FY 2013.
      b) Provide the name and type of pharmaceutical provider, pharmacy benefits manager, and/or wholesaler currently used.
      c) Describe the State/Territory mechanisms for monitoring the contract or subcontract.
      d) Describe the pharmacy network used in FY 2013 for distribution (e.g., national drug chain, mail order, state health department pharmacies, local pharmacies, university or disproportionate share hospital pharmacy), including the number of contract pharmacies used.

(2) If the program utilizes HRSA's Prime Vendor Program/HealthCare Purchasing Partners International (HPPI), provide the name of the wholesaler the contractor uses.

a) Describe any negotiated discounts on the purchase price of drugs, dispensing fees, administrative fees, and additional services for the coming year

(3) 340B Rebate Option

a) Describe the mechanisms, and timelines used by the State/Territory to identify, request, track, and utilize rebates accessed.
b) Describe how the State/Territory ensures that manufacturer's rebates are applied, consistent with Section 2616(g) of the PHS Act.

(4) 340B Hybrid States

a) For States that distribute medications utilizing both 340B mechanisms, please describe the contract with the 340B eligible clinic and describe the network pharmacy for ADAP-eligible clients that are not receiving their care at the 340B eligible clinic.
b) Please describe the percentage of clients that receive their medications at the 340B Direct Purchase program at the Clinic site and the percentage of ADAP-eligible clients that receive their medications through the network pharmacies.
c) Describe how the program ensures that only network pharmacy claims are submitted for 340B rebates.

(5) Dually Eligible 340B States:

This section is for States that distribute their medications through the 340B Direct Purchase model, but collect rebates on ADAP-eligible clients with insurance or Medicare Part D.

a) Provide the number of clients that receive medications from the Direct Purchase pharmacy services and the number of ADAP-eligible that receive insurance services from the ADAP.
b) Describe how the program ensures that only insurance assistance claims are sent forth for 340B rebates.

***Note**: Funds received as a result of participating in the 340B Drug Pricing Program Rebate Option must be returned to the operating budget of the Part B program, with priority given to activities in ADAP.*

e. Department of Defense (DOD) Direct Purchase

This section only applies to the District of Columbia.

(1) The District of Columbia is eligible for Department of Defense (DOD) pricing as well as 340B participation.

(2) For the 340B Drug Pricing Program, describe all of the cost-saving strategies used by your ADAP during FY 2013, including any non-340B supplemental rebates and/or discounts received from pharmaceutical manufacturers. Explain how these strategies resulted in additional cost savings of medications purchased directly through the DOD or the 340B program.

f. ADAP Linkages

(1) Discuss how the ADAP coordinates with third-party payers (e.g., State Medicaid program or private insurance) to assure that ADAP is the payer of last resort.
(2) Describe any third-party payer limitations that restrict access to HIV pharmaceutical therapies and describe ADAP mechanisms to address gaps or limitations in services.
(3) Describe how the ADAP coordinates with Part A, Part C, and Part D grantees to provide comprehensive and equitable pharmacy benefits across the state.
(4) Briefly describe how the ADAP utilizes or coordinates with manufacturer's Patient Assistance Programs (PAP) and clinical trials.

4) **ADAP Funded Health Insurance**
HAB Policy Notice 07-05 and HAB Policy Clarification Notice 13-05 allows States and Territories to use ADAP funds to purchase health insurance. In accordance with HAB's Policy Notice 07-05 and HAB Policy Clarification Notice 13-05, prior to the use of ADAP funds for the purchase of health insurance States must provide HAB with the methodology used by the State to ensure that the methodology requirements are met. ***States may use this application as the Notification of Intent.*** *HAB Policy Notice - 07-05 and HAB Policy Clarification Notice 13-05 can be found at:*
http://hab.hrsa.gov/manageyourgrant/policiesletters.html.

a. Notification of Intent: Does the ADAP plan to utilize funds for health insurance assistance? Please respond yes or no.
b. For States/Territories with existing ADAP-funded health insurance programs, please describe:
   (1) The use of ADAP funds to purchase insurance in FY 2013 and any anticipated changes for FY 2014;
   (2) The anticipated amounts of ADAP funds to be used for health insurance, the types of insurance(s) that will be purchased, and the number of projected clients to be served; and
   (3) The current number of clients receiving ADAP-funded insurance assistance with incomes above 138% of FPL; and the percentage of current ADAP-funded insurance eligible clients that this number represents.

c. For those States/Territories establishing new insurance programs during FY 2014, please provide a narrative description of:
   (1) How the State/Territory will ensure that the health insurance to be purchased includes a formulary that is as comprehensive as the current ADAP formulary;
   (2) How the State/Territory will ensure the cost effectiveness of the health insurance to be purchased exceeds the cost effectives of keeping clients on traditional ADAP;
   (3) The anticipated amounts of ADAP funds to be used for health insurance (i.e. premiums, co-pays and deductibles) and types of insurance(s) that will be purchased using ADAP funds;
   (4) The anticipated number of clients with incomes above 138% of FPL that are projected to be served by the new ADAP-funded insurance program in FY 2014;
   (5) How the program will account for, and report on, funds used to purchase and maintain insurance policies for eligible clients, including covering any costs associated with these policies (e.g., premiums, co-payments, or deductibles) to

ensure that the Ryan White HIV/AIDS Program is the payer of last resort;

(6) How the program coordinates with any other existing programs utilizing funds for the purchase of health insurance; and

(7) How the implementation of this program will impact the ADAP (e.g., the expansion of formulary or the decrease in waiting list).

d. If the State has plans for Medicaid expansion during FY 2014, specify:

(1) The current number of ADAP-eligible clients with incomes below 138% of FPL that will be eligible to be enrolled in Medicaid; and the percentage of current ADAP eligible clients that this number represents.

e. For States not expanding Medicaid during FY 2014, specify:

(1) The current number of ADAP-eligible clients with incomes below 100% of FPL; and the percentage of current ADAP eligible clients that this number represents; and

(2) The current number of ADAP-eligible clients with incomes between 100% and 138% of FPL; and the percentage of current ADAP eligible clients that this number represents.

f. Medicare (including Part D Prescription Drug Benefit)

(1) Has the ADAP executed a data-sharing agreement with CMS?

(2) Describe how the ADAP provides insurance assistance (premiums, deductibles, co-insurance, True Out Of Pocket (TrOOP) expenditures) to ADAP-eligible clients with prescription coverage under Medicare Part D.

(3) How many ADAP-eligible clients does your program anticipate providing Medicare Part D insurance assistance to in FY2014?

(4) What is the projected cost of providing ADAP-eligible clients with insurance assistance in FY2014?

5) Flexibility Policy as it Relates to Access, Adherence and Monitoring Services

The Use of Ryan White HIV/AIDS Program, Part B ADAP Funds for Access, Adherence, and Monitoring Services HAB Policy Notice - 07-03 http://hab.hrsa.gov/manageyourgrant/policiesletters.html established guidelines for allowable ADAP-related expenditures under the Ryan White HIV/AIDS Program for services that improve access to medications, increase adherence to medication regimens, and help clients monitor their progress in taking HIV-related medications. The policy provides grantees with greater flexibility in the use of ADAP funds. States may request to redirect up to 5% under this policy, and up to 10% in extraordinary circumstances. The amount that a grantee can request to be redirected is in addition to the aggregate of 15% of ADAP funds allowed for administrative, planning and evaluation costs. This does not include funds under other Parts that may be used to purchase medications. An example of an extraordinary circumstance would be identifying a targeted population with low adherence rates (e.g. substance abusers, homeless persons).

Note: *Those States/Territories applying to use ADAP funds under the Flexibility Policy in FY 2014 for access, adherence, and monitoring services should reply to this section. In order to be eligible the States/Territories cannot have any program restrictions (i.e., cost sharing or waiting list).*

a. Discussion of Proposed Program

1. If you are requesting to redirect a portion of ADAP funding to pay for services

under the ADAP Flexibility Policy, provide a narrative description that includes the:

(1) Proposed services to be funded (access, adherence, monitoring);
(2) Amount of ADAP funds that will be redirected to pay for the referenced services and percentage of ADAP funds for proposed services under the Flexibility Policy;
(3) Methodology used to determine the cost of the proposed services;
(4) The total projected expenditures for each service, and the unit cost (e.g. cost for billable hours for adherence and access services, lab services, etc.);
(5) The number of clients who will directly benefit from each of the proposed services;
(6) How the program will monitor the proposed services to ensure that there are no limitations to accessing the State ADAP;
(7) How the ADAP will ensure that comprehensive coverage of antiretroviral and opportunistic infection medications is maintained;
(8) How the ADAP will report on the use of redirected funds under the Flexibility Policy;
(9) How the ADAP will redirect funds back to the ADAP funding stream should it become necessary to maintain the core purpose of ADAP.

- *WORK PLAN*

This section should describe the activities proposed for ADAP in the Methodology section above. The Implementation Plan and Clinical Quality Management Plan information provided in the Part B Formula Base section above apply to this section. A different separate work plan is not needed. Grantees should use the work plan developed for the Part B Base.

- *RESOLUTION OF CHALLENGES*

This section should discuss the challenges that will likely be encountered in the implementation of ADAP activities described above in the Work Plan.

1) **This section is to be completed by States that <u>implemented</u> a Waiting list in FY 2013.** States with a waiting list newly implemented in FY 2013 should describe the process of deciding and implementing the waiting list. States with ongoing waiting lists or no waiting lists in FY 2013 can skip the remaining questions, and proceed to the next section.

   a. What factors (e.g. state general fund cuts, increased enrollment, increased costs of medications or insurance premiums, etc.) contributed to the decision to implement an ADAP waiting list?
   b. Describe how stakeholders (e.g. ADAP Advisory Body, PLWH, providers) were involved in the decision to begin a waiting list. Describe the process you employed to communicate the implementation of a waiting list to stakeholders, providers, PLWH case managers and eligibility specialists.
   c. What preventative measures and cost containment measures were implemented prior to implementing a waiting list (e.g. formulary reduction, reducing the federal poverty level (FPL) requirement, cutting support or core medical services funding, data sharing agreement with CMS, back-billing Medicaid, and purchasing of insurance)?

d. Describe the process the program has employed for training and informing PLWH, doctors, providers, eligibility specialist and case managers about the availability of medications through the Pharmaceutical Manufacturer Patient Assistance Programs.
e. Are all clients on the waiting list screened for ADAP eligibility? How often are they re-screened for ADAP eligibility? Is the waiting list based on prioritizing the clinical acuity of PLWH health or based on the model of "first come, first served"? Please provide a description of the State ADAP waiting list protocol.
f. Describe the process of how PLWH on the current ADAP waiting lists are transitioned into the ADAP when openings arise. How are PLWH and providers informed about the ADAP waiting list protocols and prioritization procedures?
g. Describe how the program coordinates with other Ryan White programs in the State to ensure that ADAP eligible PLWH have access to medications.
h. How is this information about the waiting list status communicated and monitored by the program?
i. What challenges are clients, case managers, doctors, eligibility specialists and providers facing in enrolling clients on Patient Assistance Programs?
j. What steps has the program taken to assist in meeting these challenges?
k. What is the average length of time (i.e. 1 month, 3 months, etc.) that an ADAP eligible PLWH stays on the current waiting list?
l. How many ADAP eligible PLWH does the ADAP program estimate will be on the waiting list at the end of the 2013 grant year?
m. How many ADAP eligible PLWH does the ADAP program estimate will be on the waiting list during the 2013 grant year?

2) If the program anticipates implementing an ADAP waiting list during the 2014 grant year, please describe the following:
a. What factors (e.g. state general fund cuts, increased enrollment, increased costs of medications or insurance premiums, etc.) are contributing to the decision to implement an ADAP waiting list?
b. Describe how stakeholders (ADAP Advisory Body, PLWH, providers) will be involved in the decision to begin a waiting list. Describe the process the ADAP program will employ to communicate the implementation of a waiting list to stakeholders, providers, PLWH case managers and eligibility specialists.
c. What preventative measures and cost containment measures are being implemented prior to implementing an ADAP waiting list (e.g. formulary reduction, reducing the income eligibility, cutting support or core medical services funding, data sharing agreement with CMS, back-billing Medicaid, and purchasing of insurance)?
d. What efforts has the program undertaken to prevent the waiting list?
e. Describe the process that will be used to train and inform consumers, doctors, providers, eligibility specialists and case managers about the availability of medications through the Pharmaceutical Manufacturer Patient Assistance Programs.
f. How many ADAP eligible PLWH does the ADAP program project will be on the waiting list during the 2014 grant year?
g. Describe the plans to coordinate with other Ryan White programs in the State to ensure that ADAP eligible PLWH will have access to medications.

- *EVALUATION AND TECHNICAL SUPPORT CAPACITY*

FY 14 Implementation Plan: For the ADAP specific objectives in the FY14

Implementation Plan, describe the data and process that will be used to monitor the Implementation Plan and that will be used to improve access to ADAP medications and services.

- *ORGANIZATIONAL INFORMATION*

This section should describe the organizational structure and resources that contribute to the administration of the ADAP in compliance with legislative requirements and program expectations.

Agency Oversight/Administration

Provide a narrative that identifies any changes in the management/administration of the ADAP from FY 2013, and any proposed changes for FY 2014. Include an organizational chart if the ADAP is administered by a different agency. Place this chart in **Attachment 1.**

(C) Pacific Island Jurisdictions' FY 2014 Part B Grant Application

This Section should be completed only by eligible applicants listed:

- **Republic of the Marshall Islands**
- **Federated States of Micronesia**
- **Republic of Palau**
- **American Samoa**
- **The Commonwealth of the Northern Mariana Islands**

Note: *For those territories that are eligible to apply for the ADAP Supplement Grant Application, please refer to and complete the FY 2014 ADAP Supplemental Grant Application Section.*

- *INTRODUCTION*

This grant program is to assist States and Territories in developing and/or enhancing access to a comprehensive continuum of high quality HIV care and treatment for low-income people living with HIV. The purpose of this section is to provide a summary of the application. Provide a narrative that describes the following:

- The proposed project including the needs to be addressed, the proposed services and the population groups to be served
- The general demographics of the Territory
- The organizational structure of the Territory
- Demographics of the HIV/AIDS populations in the Territory
- The geography of the Territory

- *NEEDS ASSESSMENT*

This section provides information about needs of people living with HIV in the Pacific Island Jurisdictions.

1) The Territory's Epidemiological Information

The purpose of this section is to describe the HIV/AIDS epidemic in the Territory. Section 2617 (b)(2) of the PHS Act states that the application for Part B funds shall contain a determination of the size and demographics of the population of people with HIV/AIDS in the Territory.

Please note that both the Epidemiology table and narrative should be included as **Attachment 5**.

Important Note: For programs applying for 2014 Part B Supplemental (X08) funds, the Epidemiology table and narrative provided in **Attachment 5** of this application will be provided to the 2014 Part B Supplemental Objective Review Committee (ORC) reviewers for the purpose of scoring the Epidemiology Data section (Criterion 1) of the Part B Supplemental application. The 2014 Part B Supplemental Funding Opportunity Announcement will **not** request Epidemiology data.

a. **Table**
Summarize in a table format the HIV (non-AIDS) and AIDS prevalence by age, race/ethnicity, and exposure category through December 31, 2011. Place the table in **Attachment 5** of the application and clearly label the data sources.

b. **Narrative**
Based on the most recent Territory HIV/AIDS Epidemiologic Profile, provide a narrative description of trends in the age, race/ethnicity, and exposure categories for prevalent cases and for cases newly diagnosed and reported in the previous two years for which data is available. Place the narrative in **Attachment 5** of the application.

2) The Territory's Planning Mechanisms

a. Identify the planning entity and mechanism the Territory uses to make decisions about Part B funds. Discuss the participation of PLWH in the planning process, including what the Territory is doing to encourage and support their participation in this process.

b. Discuss how allocation decisions are made between geographically or politically separate areas, and who is involved in making these decisions.

- *METHODOLOGY*

Describe how the continuum of care for PLWH will be developed, the strategy for identifying individuals living with HIV, what HIV/AIDS resources are available, disparities in access and/or services, and what outreach efforts the Territory plans for outreach and enrollment in care.

1) The Territory's HIV/AIDS Care System

Describe the Territory's continuum of care in 2014 (i.e., primary medical care, supportive services that enable individuals to access and remain in primary care, and other health and supportive services that promote health and enhance quality of life).

a. Outline the strategy for identifying individuals with HIV/AIDS who do not know their status, making such individuals aware of their status, and enabling such individuals to access services. Focus the response using the below guidelines.
b. The strategy should include discrete goals.
c. Provide a timetable for achieving the goals, and be coordinated with other community stakeholders.
d. Describe the current availability and capacity of HIV/AIDS resources and services to provide HIV/AIDS care
    (1) Describe any plans to increase the availability or to build capacity in ,the Territory.
e. Discuss any disparities in access or services among affected subpopulations or communities.

f. Describe efforts to inform individuals living with HIV/AIDS about services and to engage individuals in HIV/AIDS care.
g. Specifically address how the Medicaid program, if applicable in the Territory, provides services to people living with HIV/AIDS, including eligibility, and which HIV/AIDS services are covered by Medicaid.
h. Describe how HIV counseling and testing services are designed to facilitate access to care for persons testing positive for HIV. In addition, describe any other linkages with early intervention services.

- *WORK PLAN*

The overall Work plan section should include the Clinical Quality Management Program plan, the implementation plan for FY 2014, and the tables with the information *outlined below.*

1) The Territory's Clinical Quality Management Program

HAB's Definition of Quality: ***"****Quality is the degree to which a health or social service meets or exceeds established professional standards and user expectations." Evaluations of the quality of care should consider: (1) the quality of the inputs; (2) the quality of the service delivery process; and (3) the quality of outcomes, in order to continuously improve systems of care for individuals and populations.*

a. The HAB has established the following minimum expectations of Ryan White HIV/AIDS Program grantees regarding quality management. At a minimum, grantees are expected to:

(1) Establish and implement a quality management plan;
(2) Establish processes for ensuring that services are provided in accordance with Department of Health and Human Services (DHHS) treatment guidelines and standards of care; and
(3) Incorporate quality-related expectations into Requests for Proposals (RFPs) and Part B contracts, if applicable.

b. Provide a narrative which describes how the Territory ensures the quality of HIV care provided to PLWH. Discuss how Part B funded services, including support services, are improving HIV-related clinical health outcomes of PLWH in the Territory.

2) The Territory's Implementation Plan for FY 2014

The Ryan White HIV/AIDS Program requires that grantees funded under Part B use not less than 75 percent of grant funds, after reductions for Program Administration and Quality, for core medical services that are needed in the service area. Core medical services are defined as follows: 1) Outpatient and ambulatory health services; 2) AIDS Drug Assistance Program treatments in accordance with Section 2616 of the PHS Act; 3) AIDS pharmaceutical assistance (local); 4) Oral health care; 5) Early Intervention Services; 6) Health insurance premium and cost sharing assistance for low-income individuals in accordance with Section 2615; 7) Home health care; 8) Medical nutrition therapy; 9) Hospice services; 10) Home and community-based health services as defined under Section 2614(c) of the PHS Act; 11) Mental health services; 12) Substance abuse outpatient care; and 13) Medical case management, including treatment adherence services.

In addition, support services in Section 2612(c) of the PHS Act are described as services, subject to approval of the Secretary, that are needed for individuals with HIV/AIDS to achieve their

medical outcomes. Support services include: 1) Case Management (non-medical); 2) Child care services; 3) Emergency Financial Assistance; 4) Food bank/home-delivered meals; 5) Health education/risk reduction; 6) Housing; 7) Legal Services; 8) Linguistic Services; 9) Medical Transportation Services; 10) Outreach Services; 11) Psychological Support Services; 12) Referral for health care/supportive services; 13) Rehabilitation Services; 14) Respite Care and 15) Treatment Adherence Counseling; and 16) Residential substance abuse treatment. All services provided by or through consortia are considered as support services.

a. Table: FY 2014 Implementation Plan:
In a table, list each service category and amounts for all Part B funding sources to include*: Part B Formula funding, AIDS Drug Assistance Program (ADAP), Minority AIDS Initiative (MAI), ADAP Supplemental (if applicable), and Emerging Communities (if applicable)* that will be allocated for each service category in FY 2014. Do not include any administrative processes. The table should be placed in **Attachment 6**.

For each service category listed:

(1) Service Category: Indicate the name of the funded Core Medical or Support Services.
(2) Total Allocation: Indicate the total amount of Ryan White Part B funds (Part B Base, ADAP, ADAP Supplemental, Emerging Communities where applicable) and Minority AIDS Initiative (MAI) (where applicable) allocated for the identified service category. Do not include any other funding sources (e.g. medication rebates or state funds).
(3) Service Goal: Indicates the overall purpose of the funded service category. The goal should be broad in focus (e.g. improve health outcomes of PLWH in the territory).
(4) Current Comprehensive Plan: State the goal in the current Comprehensive Plan that the identified service will aid in accomplishing.
(5) Objective/s: Indicate how the service goal will be accomplished. Objectives should be: narrow in focus; specific (identify the target population and activity); measurable (indicate how much or how many); attainable (must be realistically accomplished given the current resources); realistic (address and establish reasonable programmatic steps); and time sensitive (indicate a timeline during which the objective will be accomplished).
(6) Service Unit Definition: Provide the name and definition of the unit of service to be provided (e.g. one round-trip bus ride, one prescription).
(7) Quantity: Provide the number of people to be served and service units to be provided during the grant year. Section 3a) List the number of people to be served; 3b) List the total number of service units to be provided to that number of individuals.
(8) Time Frame: Indicate the estimated duration of the activity relating to the objective listed.
(9) Funds: Provide the approximate amount of Part B funds to be used to provide this service. Where multiple objectives exist beneath one service goal, break out the estimated amount of funding by each individual objective listed.
(10) Outcome: From the list of objectives select a minimum of two objectives and list one or more planned outcome measures to be tracked and include benchmarks for each outcome measure. Refer to HAB HIV Performance Measures for

additional guidance.

b. Provide a narrative that describes the following:
   (1) How the Territory will allocate funds to the core medical and supportive services as described above. If funds are not allocated to these core medical services, provide a narrative description of how the core medical services are being funded through other sources;
   (2) How the activities described in the plan will assure geographic parity in access to HIV/AIDS services throughout the Territory;
   (3) How the activities described in the plan will ensure that PLWH remain engaged in HIV/AIDS primary medical care and adhere to HIV treatments; and
   (4) How the services and their goals and objectives relate to the goals of the Healthy People 2020 initiative, particularly the objectives related to HIV listed under the tab "2020 topics and objectives". Copies of the Healthy People 2020 may be obtained from the Superintendent of Documents or downloaded at: http://www.healthypeople.gov/2020/default.aspx.

- *RESOLUTION OF CHALLENGES*

The purpose of this section is to describe any challenges that may occur in implementing the proposed activities that are described in the Work Plan and approaches that will be used to address these challenges.

- *EVALUATION AND TECHNICAL SUPPORT CAPACITY*

1) FY 14 Implementation Plan: Describe the data and process that will be used to monitor the Implementation Plan.

2) Clinical Quality Management: Describe the system and processes that will support the CQM program's requirements through effective tracking of performance outcomes. Include a description of how data is to be collected and managed that allows for accurate and timely reporting of performance measures. Describe the data collecting strategy, to collect, analyze, and track data to measure process and impact outcomes of different cultural groups (e.g. race, ethnicity) and explain how data will be used to inform program development and service delivery.

- *ORGANIZATIONAL INFORMATION*

This section should describe the organizational structure and resources that contribute to the administration of the Territory's Ryan White Program in compliance with legislative requirements and program expectations.

1) The Territory's Organizational Structure

Within the Territory's structure, identify the proposed entity or entities responsible for managing and administering Part B programs, including ministry or department, unit, staff, fiscal agents, and planning/advisory/evaluation bodies. Highlight any changes that occurred over the past year or that are planned for the next year.

a. Identify the entity responsible for financial management of the Part B program, including ministry or department.
b. Describe how the fiscal and program entities work together to fulfill grant-related

reporting and monitoring responsibilities.

2) **The Territory's Ryan White HIV/AIDS Program Coordination of Planning and Services**
   a. Coordination with other Federal Programs:
      (1) Describe how the Part B program coordinates HIV/AIDS funding and service delivery with non-Ryan White HIV/AIDS Program programs.
      Examples Include: coordinating with other HRSA funded programs (including Maternal and Child Health, Migrant Health Programs, and Community Health Clinics); CDC (Prevention, Surveillance, STD programs); Medicaid (including Medicaid managed care); Medicare; Veterans Affairs programs; Territory funds; and other programs/initiatives (such as substance abuse prevention and treatment services or Territory social, welfare, and immigration services).
      (2) For those Territories eligible for Global AIDS Funds, describe any ongoing or planned activities the Territory is participating in through the Global AIDS Fund and how these activities are coordinated with the Part B program.

(D) ADAP Supplemental Grant Application

This section should be completed only by eligible applicants as listed below.

States/Territories Eligible to Apply for an ADAP Supplemental Treatment Drug Grant
Section 2618(a)(2)(F)(ii)(I-V) of the PHS Act, states that five percent of the AIDS Drug Assistance Program (ADAP) appropriation will be reserved as supplemental funding to purchase medications for States and Territories with demonstrated severe need. This funding will be available to States and Territories based on one of the following criteria as reported on the ADAP Quarterly Report:

1. *Financial requirement of Federal Poverty Level (FPL) = or <200 percent;*
2. *Limited formulary compositions for all core classes of antiretroviral medications;*
3. *Waiting list, capped enrollment, or capped expenditures;*
4. *An unanticipated increase of eligible individuals with HIV/AIDS.*

Beginning in RWHAP FY15, it is important to note that whether a State or Territory meets any of the eligibility criteria for ADAP supplemental funding will be determined on an annual basis based on the AQR/ADR. The data source for establishing eligibility for ADAP Supplemental funding is the previous reporting period of the AQR/ADR for the eligibility criteria. Receipt of ADAP supplemental funding in one year will not guarantee funding in any subsequent year.

Alabama	Kentucky	South Dakota
Alaska	Louisiana	Tennessee
Arizona	Montana	Texas
Arkansas	Nebraska	Utah
California	New Jersey	Vermont
Colorado	North Carolina	Virginia
Florida	North Dakota	Virgin Islands
Georgia	Oklahoma	Washington
Idaho	Oregon	West Virginia
Illinois	Puerto Rico	Wisconsin
Indiana	Rhode Island	Wyoming
Iowa	South Carolina	

A. Additional Eligibility Criteria

1. States/Territories must have obligated 75 percent of their FY 2013 Part B award within 120 days of receipt of grant funds and have reported on the FY 2013 interim Federal Financial Report (FFR), within 150 days after receipt of grant funds.

2. States/Territories must use ADAP supplemental funds to provide HIV/AIDS-related medications or the devices needed to administer them, and shall coordinate the use of such funds with the amounts otherwise provided under section 2616 of the PHS Act (ADAP) in order to maximize drug coverage.

B. If the ADAP is requesting a waiver to the Match pursuant to Section 2618(a)(2)(F)(ii)(III) of the PHS Act, please attach a waiver request letter as **Attachment 13**. Submit this request along with the other application information.

- *INTRODUCTION*

The State/Territory with demonstrated severe need should include a description of how the project will use supplemental funds to pay for medications to treat HIV disease.

- *NEEDS ASSESSMENT*

States and Territories applying for these funds must describe the severity of need for ADAP supplemental funds using the factors below.

1) Describe any ADAP eligibility restrictions.

2) Identify the barriers in meeting the requirement for maintaining a minimum drug list that includes all currently available Food and Drug Administration (FDA)-approved antiretroviral drug classes. *The current statute requires that all States/Territories determine the formularies from the list of core classes of antiretroviral medications*

established by the Secretary. ADAPs are required to include at least one drug from each FDA-approved antiretroviral drug classes currently available including Fusion/Entry Inhibitors, Non-nucleoside Reverse Transcriptase Inhibitors, Nucleoside/nucleotide Reverse Transcriptase Inhibitors, Protease Inhibitors and Integrase Inhibitors.

3) Identify the number of eligible individuals to whom a State or Territory is unable to provide therapeutics to treat HIV/AIDS.

4) Discuss any unanticipated increase in service utilization and program costs (i.e. due to the addition of a new drug or class of drug, or to an unexpected increase in eligible individuals with HIV/AIDS.)

- *METHODOLOGY*

The methodology section responses in the Part B Formula/Base and ADAP Earmark sections apply to this section. No further information is required for this section.

- *WORK PLAN*

The FY 14 Implementation Plan provided in the Part B Formula/Base and ADAP Earmark sections apply to this section. Please add the information regarding the services that will be provided with this funding following the format of the FY14 Implementation Plan.

1) Objective/s: List objectives for the ADAP Supplemental services. Each objective should describe the specific activities associated with the service being provided.
2) Service Unit Definition: Provide the name and definition of the unit of service to be provided (e.g. one round-trip bus ride, one prescription).
3) Quantity: Provide the number of people to be served and service units to be provided during the grant year. Section 3a) List the number of people to be served; 3b) List the total number of service units to be provided to that number of individuals.
4) Time Frame: Indicate the estimated duration of the activity relating to the objective listed.
5) Funds: Provide the approximate amount of ADAP Supplemental funds to be used to provide this service.

- *RESOLUTION OF CHALLENGES*

The Resolution of Challenges section responses in the ADAP Earmark sections apply to this section. No further information is required for this section.

- *EVALUATION AND TECHNICAL SUPPORT CAPACITY*

Describe the data and process that will be used to monitor the ADAP Supplemental specific objectives. No further information is required for this section.

- *ORGANIZATIONAL INFORMATION*

The Organization Information provided in the Part B Formula/Base sections and the ADAP section above applies to this section. No further information is required for this section.

(E) Emerging Communities FY 2014 Grant Application

This section should be completed only by eligible applicants as listed below.
The following States are responsible for applying for the eligible Metropolitan Statistical Areas

(MSAs) below:

States	Emerging Communities
Alabama	Birmingham-Hoover, AL MSA
California	Bakersfield, CA MSA
Delaware	Phil., PA-NJ-DE-MD MSA – Wilmington
Florida	Lakeland, FL MSA Port St. Lucie-Fort Pierce, FL MSA Sarasota-Bradenton-Venice, FL MSA
Georgia	Augusta-Richmond County, GA-SC MSA
Kentucky	Louisville, KY-IN MSA
Mississippi	Jackson, MS MSA
New York	Albany-Schenectady-Troy, NY MSA Buffalo-Niagara Falls, NY MSA Rochester, NY MSA
North Carolina	Raleigh-Cary, NC MSA
Ohio	Cincinnati-Middletown, OH-KY-IN, MSA Columbus, OH MSA
Oklahoma	Oklahoma City, OK MSA
Pennsylvania	Pittsburgh, PA MSA
Rhode Island	Providence-New Bedford-Fall River, RI-MA MSA
South Carolina	Columbia, SC MSA Charleston, SC MSA
Virginia	Richmond, VA MSA
Wisconsin	Milwaukee-Waukesha-West Allis, WI MSA
Total: 16 States	Total: 22 Emerging Communities

Program Authority and Eligibility

The Emerging Communities Supplemental Grant award is authorized under Section 2621 of PHS Act. It is intended to enable eligible States to provide comprehensive services of the type described in section 2612(a) of the PHS Act to supplement the services otherwise provided by the State under a grant under Part B in emerging communities within the State that are not eligible to receive grants under Part A. An eligible State shall agree that the grant will be used to provide funds directly to emerging communities in the State, separately from other funds under this title that are provided by the State to such communities.

Grantees with Jurisdictions that were classified as an Emerging Community (EC) are eligible to apply for these funds. Emerging Communities continue their eligibility for these funds so long as they meet the statutory requirements. Areas must meet the statutory incidence requirements (cumulative AIDS cases reported to and confirmed by the Director of the Centers for Disease Control and Prevention during the most recent period of 5 calendar years for which such data are available). An Emerging Community must have between 500-999 cumulative AIDS cases during the most recent 5 years. In the alternative, areas can retain their eligibility by meeting the savings provisions of the Ryan White Program legislation. That is, they must not have fallen below, for three consecutive years, the required incidence level already specified AND required prevalence level (cumulative total of living cases of AIDS reported to and confirmed by the Director of the Centers for Disease Control and Prevention as of December 31 of the most recent calendar year for which such data are available). Areas are notified by letter when they fall

within the savings provisions of the Ryan White Program legislation. According to the past eligibility numbers, all the above ECs will be eligible in FY 2014.

- *INTRODUCTION*

The purpose of the Emerging Community Supplemental Funds under Part B is to enhance a comprehensive array of Ryan White core and supportive services for communities in need within the Metropolitan Statistical Areas (MSAs) that are not eligible to receive additional grants under Part A. Please briefly describe what the Emerging Community funding will be used for in the MSA.

- *NEEDS ASSESSMENT*

1) Planned Services for Emerging Community Funds

a. Please describe how the planning process for the Emerging Community funds meets the following requirements. *(A State with multiple Emerging Communities should describe each Emerging Community planning process separately, if the process differs.)*

(1) The allocation of the funds is based in accordance with the local demographic incidence of HIV/AIDS including appropriate allocations for services for infants, children, women and families with HIV/AIDS;
(2) Affected communities and people living with HIV/AIDS are included in the planning process; and
(3) The proposed services are consistent with the local needs assessments and the most recent Statewide Coordinated Statement of Need.

- *METHODOLOGY*

Please describe the following:

1) How the State disseminates/will disseminate Emerging Community funds within the Metropolitan Statistical Area;
2) How the State will ensure that the current level of support for the activities in the Emerging Community is not supplanted by this funding; and
3) How the State utilizes the funds in a manner that is responsive to the needs of the MSA and are cost effective.

- *WORK PLAN*

1) Implementation Plan for Emerging Community Funds
Describe how, as a result of the planning process, the Emerging Community funds will be used. A State with multiple Emerging Communities should describe the use of funds for each Emerging Community separately. Please describe:

a. What services were provided in Fiscal Year 2013 using Emerging Community funds?
b. What services will be provided in Fiscal Year 2014?

Note: *The 75% core medical services requirement does not apply to Emerging Community funds.*

- *RESOLUTION OF CHALLENGES*

The purpose of this section is to describe any challenges that may occur in implementing the proposed activities that are described in the Work Plan and approaches that will be used to address these challenges.

- *EVALUATION AND TECHNICAL SUPPORT CAPACITY*

Describe the data and process that will be used to monitor the objectives in the FY14 Emerging Communities Implementation Plan as provided above.

- *ORGANIZATIONAL INFORMATION*

The Organization Information section responses in the Part B Formula/Base apply to this section.

iii. Budget and Budget Justification Narrative

In addition to the instructions in Section 4.1.iv and v. of HRSA's *SF-424 Application Guide* the (FY) 2014 Ryan White HIV/AIDS Program - Part B Formula/Base, Minority AIDS Initiative, AIDS Drug Assistance Program Earmark, Pacific Island Jurisdiction, ADAP Supplemental Awards, and Emerging Communities program requires the following:

Please complete Sections A, B, E, and F of the SF-424A Budget Information – Non-Construction Programs form included with HRSA's *SF-424 Application Guide* for the year of the project period, and then provide a line item budget using Section B Object Class Categories of the SF-424A.

In Section B, the four required columns are:

1) **Administration** - This column should include all funds allocated to the following grant activities: grantee administration, planning and evaluation, and quality management;
2) **ADAP** - This column should include all funds allocated to the following grant activities: ADAP;
3) **Consortia** - This column should include all funds allocated to consortia and emerging communities; and
4) **Direct Services** - This column should include all funds allocated to the following grant activities: state direct services, home and community-based care, MAI, and health insurance continuation.

Provide a narrative that explains the amounts requested for each line in the budget. The budget justification should specifically describe how each item will support the achievement of proposed objectives. The budget period is for ONE year. Line item information must be provided to explain the costs entered in the SF-424A. Be very careful about showing how each item in the "other" category is justified. The budget justification MUST be concise. Do NOT use the justification to expand the project narrative.

The budget narrative should be submitted in the same format as the FY13 revised budget narrative. The format should explain the amounts requested for the following: Part B Base, ADAP, ADAP Supplemental, Consortia, Emerging Communities, and Minority AIDS Initiative (MAI), and the relevant Ryan White Budget Categories. The narrative should explain how the line items listed support the overall service delivery system and include justification for any applicable Object Class Categories: Personnel, Fringe Benefits, Travel, Equipment, Supplies, Contractual, Construction, Other and Indirect Charges. For employees who are less than one (1) FTE on the grant, please identify all funding sources outside of Ryan White Part B funding for Personnel and Fringe Benefits costs.

Caps on Expenses: Part B grantee administrative costs may not exceed 10% of the total grant award. Planning and Evaluation costs may not exceed 10% of the total grant award. Collectively, Grantee Administration, and Planning and Evaluation may not exceed 15% of the total award. Grantees may allocate up to 5% of the total grant award or $3,000,000 (whichever is less) for Clinical Quality Management. In the case of entities and subcontractors to which the chief elected official of an eligible area allocates amounts received by the official under a grant under this part, the official shall ensure that, the aggregate amount so allocated, the total of the expenditures by such entities for administrative expenses does not exceed 10 percent (without regard to whether particular entities expend more than 10 percent for such expenses).

Indirect Costs: Indirect costs are those costs incurred for common or joint objectives which cannot be readily identified but are necessary to the operations of the organization, e.g., the cost of operating and maintaining facilities, depreciation, and administrative salaries. For institutions subject to OMB Circular A-21, the term "facilities and administration" is used to denote indirect costs. If an organization applying for an assistance award does not have an indirect cost rate, the applicant may wish to obtain one through HHS's Division of Cost Allocation (DCA). Visit DCA's website at: https://rates.psc.gov/ to learn more about rate agreements, the process for applying for them, and the regional offices which negotiate them. The indirect cost rate agreement will not count toward the page limit.

Payer of Last Resort: The Ryan White HIV/AIDS Program is the payer of last resort, and grantees must make every effort to ensure that alternate sources of payments are pursued. HRSA expects grantees to certify eligibility annually and recertify eligibility every six months (Please see HAB Policy 13-02 at http://hab.hrsa.gov/manageyourgrant/pinspals/pcn1302clienteligibility.pdf).
Grantees are required to use effective strategies to coordinate with third party payers that are ultimately responsible for covering the cost of services provided to eligible or covered persons. Third party sources include, Medicaid, State Children's Health Insurance Programs (SCHIP), Medicare, including Medicare Part D, basic health plans, and private insurance, including those purchased through the Marketplaces. Subcontractors providing Medicaid eligible services must be Medicaid certified.

Program Income: HHS Grant Regulations require recipients and/or sub-recipients to collect and report program income. Program income shall be monitored by the recipient, retained by the recipient (or sub-recipient if earned at the sub-recipient level), and used to provide ADAP services to eligible clients. "Program income is gross income—earned by a recipient, sub-recipient, or a contractor under a grant—directly generated by the grant-supported activity or earned as a result of the award. Program income includes, but is not limited to, income from fees for services performed (e.g., direct payment, or reimbursements received from Medicaid,

Medicare and third-party insurance); and income a recipient or sub-recipient earns as the result of a benefit made possible by receipt of a grant or grant funds."

Rebate funds are not Ryan White program income. See HRSA/HAB "Use of Rebate Funds" Policy Letter, dated November 16, 2012 http://hab.hrsa.gov/manageyourgrant/pinspals/habpl1112.pdf.

Direct payments include charges imposed by recipients and sub-recipients for Part B ADAP services as required under Section 2617(c) of the PHS Act. The 2014 Notice of Award will specify that program income must be "Added to funds committed to the project or program and used to further eligible project or program objectives." Grantees are responsible for ensuring that sub-recipients have systems in place to account for program income, and for monitoring to ensure that sub-recipients are tracking and using program income consistent with Part B requirements. See the HHS Grants Policy Statement at (http://dhhs.gov/asfr/ogapa/grantinformation/hhsgps107.pdf) and 45 CFR 92.25.

- Applicants seeking a waiver of the core medical services requirement (Section 2612(b)(2) of the PHS Act) must submit a waiver request either with this grant application, anytime up to the application submission, or up to four months after the grant award for FY 2014. Submission should be in accordance with the information and criteria published by HRSA in the Federal Register Notice, Vol. 78, No. 101, dated Friday, May 24, 2013, and may be found at http://www.gpo.gov/fdsys/pkg/FR-2013-05-24/pdf/2013-12354.pdf.
  In addition, grantees are advised that a FY 2014 Part B waiver request must include funds awarded under the MAI. A waiver request that does not include MAI will not be considered. A core medical services waiver request, if submitted with this application, should be included as **Attachment 8**.

- Ryan White Part B Agreements and Compliance Assurances are included (**Appendix A**) with this FOA and require the signature of the CEO, or of his or her designee. This document should be included as **Attachment 12**.

The General Provisions in Division F, Title V of the Consolidated Appropriations Act, 2012 (P.L. 112-74) and continued through the *Consolidated and Further Continuing Appropriations Act, 2013 (P. L. 113-6)*, apply to this program. These provisions include a salary rate limitation. Please see Section **4.1.iv Budget – Salary Limitation** of HRSA's *SF-424 Application Guide* for additional information.

iv. Attachments

Please provide the following items in the order specified below to complete the content of the application. Please note that these are supplementary in nature, and are not intended to be a continuation of the project narrative. Unless otherwise noted, attachments count toward the application page limit. Each attachment must be clearly labeled.

Attachment 1: Project Organizational Chart
Provide a one-page figure that depicts the organizational structure of the project.

Attachment 2: Staffing Plan and Job Descriptions for Key Personnel (see section 4.1. of the HRSA's SF-424 Application Guide)

Keep each job description to one page in length as much as is possible. Include the role, responsibilities, and qualifications of proposed project staff.

Attachment 3: Biographical Sketches of Key Personnel

Include biographical sketches for persons occupying the key positions described in Attachment 2, not to exceed two pages in length. In the event that a biographical sketch is included for an identified individual who is not yet hired, please include a letter of commitment from that person with the biographical sketch.

Attachment 4: ADAP Funding Sources Table

Attachment 5: HIV/AIDS Epidemiology Table and Narrative

Attachment 6: Implementation Plan (includes MAI, if applicable)

Attachment 7: Maintenance of Effort Documentation

Applicants must provide a baseline aggregate expenditure for the prior two fiscal years.

Example:

NON-FEDERAL EXPENDITURES

FY 20XX (Actual) Actual FY 20XX non-Federal funds, including in-kind, expended for activities proposed in this application. Amount: $_____	FY 20XX (Actual) Actual FY 20XX non-Federal funds, including in-kind, designated for activities proposed in this application. Amount: $_____

Attachment 8: Unmet Need Framework and Narrative

Attachment 9: FY 2014 Core Medical Services Waiver Request (if submitting with the application)

Attachment 10: Match Information

Attachments 11: MAI Waiver

Attachment 12: Ryan White Part B Agreements and Compliance Assurances

Attachment 13: Match Waiver Request

Attachment 14 – 15: Other Relevant Documents

Include here any other documents that are relevant to the application, including letters of support. Letters of support must be dated and specifically indicate a commitment to the project/program (in-kind services, dollars, staff, space, equipment, etc.) List all other support letters on one page.

3. Submission Dates and Times

Application Due Date
The due date for applications under this funding opportunity announcement is *December 9, 2013 at 11:59 P.M. Eastern Time*.

4. Intergovernmental Review

The HIV Care Grant Program Part B is not subject to the provisions of Executive Order 12372, as implemented by 45 CFR 100.

5. Funding Restrictions

Applicants responding to this announcement may request funding for a project period of up to one (1) year.

The DSHAP will be strictly enforcing the Ryan White HIV/AIDS Program authorizing statute, which states:

Section 2618(c)(1)--Expedited Distribution,-

- IN GENERAL, Section 2618(c)(1)(B)--- Not less than 75 percent of the amounts received under a grant awarded to a State under section 2611shall be obligated to specific programs and projects and made available for expenditure not later than –
- (A) in the case of the first fiscal year for which amounts are received, 150 days after the receipt of such amounts by the State; and
- (B) in the case of succeeding fiscal years (FY), 120 days after receipt of such amounts by the State.

Section 2618(d)--Reallocation-
(2)Any portion of a grant made to a state under section 2611 for a fiscal year that has not been obligated as described in subsection (c) ceases to be available to the State or Territory and shall be made available by the Secretary for grants under Section 2620, in addition to amounts made available for such grants under section 2623(b)(2).

Part B grant funds **cannot** be used for:

1. International travel
2. Construction (However, minor alterations and renovations to an existing facility, to make it more suitable for the purpose of the grant program is allowable with prior HRSA approval.)
3. Entertainment costs (This includes the cost of amusements, social activities and related incidental costs.)
4. Fundraising expenses
5. Lobbying expenses
6. Pre-Exposure Prophylaxis (PrEP)
7. Syringe Services Programs (SSPs)

Reminder: The Part B legislation defines Grantee Administration to include indirect costs. If a grantee chooses to charge an indirect cost to the grant, they **must** apply for and obtain an HHS

negotiated indirect cost rate through HHS's Division of Cost Allocation (DCA); the total amount allocated for Grantee Administration *(including indirect costs)* may not exceed the 10% Administrative cap. Sub-grantees cannot request an HHS negotiated indirect cost rate under this grant through the HHS Division of Cost Allocation. For further information regarding allowable costs, please refer to: http://hab.hrsa.gov/manageyourgrant/policiesletters.html.

Other non-allowable costs can be found in the OMB circulars, available at http://www.whitehouse.gov/omb/circulars_default.

Program Income: All program income generated as a result of awarded grant funds must be used for approved project-related activities.

HHS Grant Regulations require recipients and/or sub-recipients to collect and report program income. Program income shall be monitored by the recipient, retained by the recipient (or sub-recipient if earned at the sub-recipient level), and used to provide ADAP services to eligible clients. "Program income is gross income—earned by a recipient, sub-recipient, or a contractor under a grant—directly generated by the grant-supported activity or earned as a result of the award. Program income includes, but is not limited to, income from fees for services performed (e.g., direct payment, or reimbursements received from Medicaid, Medicare and third-party insurance); and income a recipient or sub-recipient earns as the result of a benefit made possible by receipt of a grant or grant funds."

Rebate funds are not Ryan White program income. See HRSA/HAB "Use of Rebate Funds" Policy Letter, dated November 16, 2012 http://hab.hrsa.gov/manageyourgrant/pinspals/habpl1112.pdf.

Direct payments include charges imposed by recipients and sub-recipients for Part B ADAP services as required under Section 2617(c) of Title XXVI of the PHS Act, as amended by the Ryan White HIV/AIDS Treatment Extension Act of 2009 (Public Law 111-87), such as enrollment fees, premiums, deductibles, cost sharing, co-payments, co-insurance, or other charges. The 2013 Notice of Award will specify that program income must be "Added to funds committed to the project or program and used to further eligible project or program objectives." Grantees are responsible for ensuring that sub-recipients have systems in place to account for program income, and for monitoring to ensure that sub-recipients are tracking and using program income consistent with Part B requirements. See the HHS Grants Policy Statement at (http://dhhs.gov/asfr/ogapa/grantinformation/hhsgps107.pdf) and 45 CFR 92.25.

The General Provisions in Division F, Title V of the Consolidated Appropriations Act, 2012 (P.L. 112-74) and continued through the *Consolidated and Further Continuing Appropriations Act, 2013 (P. L. 113-6)*, apply to this program. Please see Section 4.1 of HRSA's *SF-424 Application Guide* for additional information.

V. Application Review Information

1. Review Criteria

Applications will be reviewed for completeness of submission of required information as follows:

- Project Organizational Chart
- Staffing Plan and Job Descriptions for Key Personnel
- Biographical Sketches of Key Personnel
- ADAP Funding Sources Table
- HIV/AIDS Epidemiology Table and Narrative
- Implementation Plan (includes MAI, if applicable)
- Maintenance of Effort Documentation, if applicable.
- Unmet Need Framework and Narrative
- FY 2014 Core Medical Services Waiver Request
- State Match Information
- MAI Waiver
- Ryan White Part B agreements and Compliance Assurances
- ADAP Supplemental Match Waiver Request
- Grantee Administration and Accountability
- Early Identification of Individuals with HIV/AIDS
- Clinical Quality Management
- WICY

The Ryan White HIV/AIDS Program Part B does not have funding priorities based on scoring because the funds are distributed according to a formula.

Part B formula/base, ADAP and Emerging Communities awards are based on the number of reported living cases of HIV/AIDS cases in the State or Territory in the most recent calendar year as confirmed by CDC submitted to HRSA. Similarly, for grantees applying for MAI formula funds, awards are based on the number of reported and confirmed living minority cases of HIV/AIDS for the most recent calendar year submitted to HRSA. The most recently completed calendar year ended December 31, 2012. Supplemental ADAP grants are awarded by formula to states meeting any of the criteria indicated in that section of the FOA.

2. Review and Selection Process

Please see section 5.3 of the HRSA's *SF-424 Application Guide*.

3. Anticipated Announcement and Award Dates

It is anticipated that awards will be announced prior to the start date of April 1, 2014.

VI. Award Administration Information

1. Award Notices

The Notice of Award will be sent prior to the start date of April 1, 2014. See section 5.4 of HRSA's *SF-424 Application Guide* for additional information.

2. Administrative and National Policy Requirements

See section 2 of HRSA's *SF-424 Application Guide*.

3. Reporting

The successful applicant under this funding opportunity announcement must comply with Section 6 of HRSA's *SF-424 Application Guide* and the following reporting and review activities:

1) **Ryan White Services Report**(s): Acceptance of this award indicates that the grantee assures that it will comply with data requirements of the Ryan White Services Report (RSR) and that it will mandate compliance by each of its contractors and subcontractors. The RSR captures information necessary to demonstrate program performance and accountability. All Ryan White core service and support service providers are required to submit client-level data for Calendar Year (CY) 2013. Please refer to the HIV/AIDS Program Client Level Data website at http://hab.hrsa.gov/manageyourgrant/clientleveldata.html for additional information.

2) **ADAP Quarterly Report:** Information regarding the ADAP Quarterly Report will be provided in your Notice of Award. Further information can be found at: http://hab.hrsa.gov/manageyourgrant/reportingrequirements.html

   The ADAP Quarterly Report (AQR) will be phased out and replaced with the ADAP Data Report as that report becomes more robust.

3) **ADAP Data Report**: The ADAP Data Report (ADR) is a reporting requirement for ADAPs to provide client-level data on individuals served, services being delivered, and costs associated with these services. The ADR replaces the AQR (ADAP Quarterly Report), which will be retired. Further information can be found at: http://hab.hrsa.gov/manageyourgrant/adr.html

VII. Agency Contacts

Applicants may obtain additional information regarding business, administrative, or fiscal issues related to this funding opportunity announcement by contacting:

Karen Mayo
Grants Management Specialist
Division of Grants Management Operations/HRSA
Parklawn Building, Room 11A-02
5600 Fishers Lane,

Rockville, Maryland 20857
Telephone: (301) 443-3555
Fax: (301) 594-4073E-mail: KMayo@hrsa.gov

Additional information related to the overall program issues and/or technical assistance regarding this funding announcement may be obtained by contacting

Heather Hauck, MSW, LICSW
Director, Division of State HIV/AIDS Programs
HIV/AIDS Bureau, HRSA
Parklawn Building, Room 7A-15
5600 Fishers Lane
Rockville, Maryland 20857
Telephone: 301-443-6745
Fax: 301-443-8143
Email: HHauck@hrsa.gov

Applicants may need assistance when working online to submit their application forms electronically. Applicants should always obtain a case number when calling for support. For assistance with submitting the application in Grants.gov, contact Grants.gov 24 hours a day, seven days a week, excluding Federal holidays at:

Grants.gov Contact Center
Telephone: 1-800-518-4726 (International Callers, please dial 606-545-5035)
E-mail: support@grants.gov
iPortal: http://grants.gov/iportal

Successful applicants/awardees may need assistance when working online to submit information and reports electronically through HRSA's Electronic Handbooks (EHBs). For assistance with submitting information in HRSA's EHBs, contact the HRSA Call Center, Monday-Friday, 9:00 a.m. to 5:30 p.m. ET:

HRSA Contact Center
Telephone: (877) 464-4772
TTY: (877) 897-9910
E-mail: CallCenter@HRSA.GOV

VIII. Other Information

1. HIV/AIDS Clinical Performance Measures

The HIV/AIDS Bureau has developed HIV/AIDS Clinical Performance Measures for Adults and Adolescents and a companion guide to assist grantees in the use and implementation of the core clinical performance measures. Information on Performance Measures can be found at: http://hab.hrsa.gov/deliverhivaidscare/habperformmeasures.html.

2. ADAP Quality Management

ADAP quality management requirements have been incorporated into the Clinical Quality Management section of this Funding Opportunity Announcement.

3. Allowable Uses of Funds

For the most up to date listing of allowable uses of funds, refer to HAB Policy Notice 10-02: "Eligible Individuals and Allowable Uses of Funds for Discretely Defined Categories of Services" reissued April 8th, 2010. HAB Policy Notice 10-02 is available online at: http://hab.hrsa.gov/manageyourgrant/policiesletters.html.

Usage of Ryan White funds for HIV testing:

Ryan White funds for testing under Early Invention Services (EIS) (sections 2612(b)(3)(E) and 2612(d) of the PHS Act) for Part B can be used to include identification of individuals at points of entry and access to services and provision of:

1. HIV testing and Targeted counseling
2. Referral services
3. Linkage to care
4. Health education and literacy training that enable clients to navigate the HIV system of care.

Note: All four EIS components must be present, but Part B funds to be used for HIV testing can be used only as necessary to supplement, not supplant existing funding for HIV testing in the State/Territory.

4. National Monitoring Standards

The HAB/DSHAP Program, Fiscal and Universal National Monitoring Standards for RW Part A and B Grantees, are available at: http://hab.hrsa.gov/manageyourgrant/granteebasics.html.

5. Program Integrity Initiative

The Program Integrity Initiative is designed to target the greatest risks of fraud, waste and abuse; reduce those risks by enhancing existing program integrity operations; share new and best program integrity practices; and measure the results of our efforts. The purpose of this message is to inform you of the HRSA efforts toward strengthening program integrity in our own Agency.

IX. Tips for Writing a Strong Application

See section 4.7 of HRSA's *SF-424 Application Guide*.

Appendix A:
FY 2014 AGREEMENTS AND ASSURANCES Ryan White HIV/AIDS Treatment Extension Act of 2009 Part B Grant Program

I, the Governor, or Authorized Designated Official, of the State or Territory of _____, hereinafter referred to as "State,"assure that:

1. Pursuant to Section 2612[1]

a.) Section 2612(a)

Amounts provided will be expended on core medical services, support services, and administrative expenses only.

b.) Section 2612(b)(1)

Unless a waiver is obtained, not less than 75 percent of the portion of the grant remaining after reserving amounts for administration, planning/evaluation and quality management will be used to provide core medical services that are needed in the State for individuals with HIV/AIDS who are identified and eligible under this title (including services regarding the co-occurring conditions of the individuals).

c.) Section 2612(d)(2)

Entities providing Early Intervention Services (EIS) will ensure that the following conditions have been met:

- Federal, State and local funds are otherwise inadequate for the EIS an entity proposes to provide; and,
- The entity will supplement, not supplant other funds available to the entity for the provision of providing EIS for the fiscal year involved.

d.) Section 2612(e)

For each of such populations in the eligible area, the State will use not less than the percentage constituted by the ratio of the population involved (infants, children, youth, or women in such area) with HIV/AIDS to the general population in such area of individuals with HIV/AIDS, unless a waiver is obtained from the Secretary.

f.) Section 2612(f)

No amounts received under the grant will be used to purchase or improve land, or to purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or to make cash payments to intended recipients of services.

2. Pursuant to Section 2613

Section 2613(b)

All required assurances will be obtained from applicants who apply to the State for assistance to provide consortia services.

3. Pursuant to Section 2615

Section 2615(b)

[1] All statutory references are to the Public Health Service Act, unless otherwise specified.

Assistance will not be used to pay any costs associated with the creation, capitalization, or administration of a liability risk pool (other than those costs paid on behalf of individuals as part of premium contributions to existing liability risk pools); or to pay any amount expended by a State under title XIX of the Social Security Act.

4. Pursuant to Section 2616

a.) Section 2616(c)(1)

The therapeutics included on the list of classes of core antiretroviral therapeutics established by the Secretary are at a minimum the treatments provided by the State.

b.) Section 2616(g)

Any drug rebates received on drugs purchased from funds provided under the grant are applied to activities supported under Part B, with priority given to AIDS Drug Assistance Program activities.

5. Pursuant to Section 2617

a.) Section 2617(b)(4)

The State shall designate a lead State agency that will:

- Administer all assistance received under Part B;
- Conduct the needs assessment and prepare the State plan;
- Prepare all applications for assistance under Part B;
- Receive notices with respect to programs under Title XXVI;
- Every two years, collect and submit to the Secretary all audits, consistent with Office of Management and Budget circular A133, from grantees within the State, including audits regarding funds expended in accordance to Part B; and
- Carry out any other duties determined appropriate by the Secretary to facilitate the coordination of programs under Title XXVI.

b.) Section 2617(b)(6)

The public health agency that is administering the grant for the State periodically convenes a meeting that includes individuals with HIV/AIDS, members of a federally recognized Indian tribe as represented in the State, representatives of grantees under each of the Ryan White HIV/AIDS Program, providers, public agency representatives, and if applicable, entities on Part A Planning Councils, in developing the statewide coordinated statement of need (SCSN).

c.) Section 2617(b)(7)(A)

The public health agency that is administering the grant for the State engages in a public advisory planning process, including public hearings, that includes individuals with HIV/AIDS, members of a federally recognized Indian tribe as represented in the State, representatives of grantees under each Part of Title XXVI of the Public Health Service Act, providers, public agency representatives, Part A Planning Councils (or other planning body), in developing the comprehensive plan and commenting on the implementation of such plan.

d.) Section 2617(b)(7)(B)(i)

HIV-related health care and support services delivered pursuant to a program established with assistance provided under Part B will be provided without regard to the ability of the individual to pay for such services and without regard to the current or past health condition of the individual living with HIV/AIDS, to the maximum extent practicable.

e.) Section 2617(b)(7)(B)(ii)
Such services will be provided in a setting that is accessible to low-income individuals living with HIV/AIDS.

f.) Section 2617(b)(7)(B)(iii)
Outreach to low-income individuals living with HIV/AIDS will be provided to inform them of the services available under Part B.

g.) Section 2617(b)(7)(B)(iv)
If using amounts provided under the grant for health insurance coverage, the State will submit a plan that assures that

- such amounts will be targeted to individuals who would not otherwise be able to afford health insurance coverage; and
- income, asset, and medical expense criteria will be established and applied by the State to identify those individuals who qualify for assistance under such a program; and that information concerning such criteria will be made available to the public.

h.) Section 2617(b)(7)(C)
The State will provide for periodic independent peer review to assess the quality and appropriateness of health and support services provided by entities that receive funds from the State under Part B.

i.) Section 2617(b)(7)(D)
The State will permit and cooperate with any Federal investigations undertaken regarding programs conducted under Part B.

j.) Section 2617(b)(7)(E)
The State will maintain HIV-related activities at a level that is equal to not less than the level of such expenditures by the State for the one-year period preceding the fiscal year for which the State is applying to receive a grant under Part B.

k.) Section 2617(b)(7)(F)
Grant funds are not utilized to make payments for any item or service to the extent that payment has been made, or reasonably can be expected to be made, with respect to that item or service

- under any State compensation program, insurance policy, Federal or State health benefits program, or
- by an entity that provides health services on a prepaid basis (except for a program administered by or providing the services of the Indian Health Services).

l.) Section 2617(b)(7)(G)
Entities within areas in which activities under the grant are carried will maintain appropriate relationships with entities in the area serviced that constitute key points of access to the health care system for individuals with HIV/AIDS (including emergency rooms, substance abuse treatment programs, detoxification centers, adult and juvenile detention facilities, STD clinics, HIV counseling and testing sites, mental health programs, and homeless shelters) and other entities under Section 2612 (c) and 2652 (a) (eligible to apply for Part B Early Intervention Service Grants) for the purpose of facilitating early intervention for individuals newly diagnosed with HIV/AIDS and individuals knowledgeable of their HIV status but not in care;

m.) Section 2617(b)(8)
The State will develop a comprehensive plan describing:

- The estimated number of individuals within the State with HIV/AIDS who do not know their status;
- Activities undertaken by the State to find such individuals and to make them aware of the their status;
- The manner in which the State will provide undiagnosed individuals who are made aware of their status with access to medical treatment for their HIV/AIDS;
- Efforts to remove legal barriers, including State laws and regulations, to routine testing.

n.) Section 2617(c)
The State will comply with the statutory requirements regarding imposition of charges for services, for those providers who charge for services.

o.) Section 2617(d)(1)
If subject to the Matching requirement detailed in Section 2617(d), non-Federal contributions will be made available (either directly or through donations from public or private entities).

6. Pursuant to Section 2618
a.) 2618(a)(2)(F)(ii)
States and Territories applying for ADAP Supplemental Treatment Drug Grants will make available non-Federal contributions (directly or through donations from public or private entities) in an amount equal to $1 for each $4 of Federal funds awarded, unless a waiver is obtained.

b.) 2618(b)(3)(A-D)
The State will comply with the limitations of grant funds for administration; planning and evaluation; and quality management activities. In the case of contractors (including Consortia), the State will ensure that, of the aggregate amount so allocated, the total of the expenditures by such entities for administrative expenses does not exceed 10% (without regard to whether particular entities expend more than 10% for such expenses).

c.) 2618(b)(3)(E)(i)
The State will provide for the establishment of a clinical quality management program to assess the extent to which HIV health services provided to patients under this grant are consistent with the most recent Public Health Service guidelines for treatment of HIV/AIDS and related opportunistic infections, and as applicable, to develop strategies for ensuring that such services are consistent with the guidelines for improvement in the access to, and quality of HIV health services.

d.) 2618(c)(1)
The State will ensure that 75% of Part B funds will be obligated within 120 days of the start date of the grant award, and that if such funds are not obligated, they will be made available promptly to the Secretary for reallocation.

7. Pursuant to Section 2622
The State will comply with statutory requirements regarding the timeframe for obligation and expenditure of funds, and will comply with any cancellation of unobligated funds.

8. Pursuant to Section 2681(d)
Services funded will be integrated with other such services, programs will be coordinated with other available programs (including Medicaid), and that the continuity of care and prevention services of individuals with HIV is enhanced.

9. Pursuant to Section 2684
No funds shall be used to fund AIDS programs, or to develop materials, designed to promote or encourage, directly, intravenous drug use or sexual activity, whether homosexual or heterosexual.

_____ Date_____
Signature

_____
Title

_____

_____
Address